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If more blanks are needed, address State Registrar, 2411 N. Charles Street, Balsimore, Requesting U. S. No. 1.

(Year)

Date of onset

Med

V. S. No.

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9.—The industry or business in which the work was done.

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| Example I                                                                      | Į.            | Example II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       | May 1,1923    | Other contributory causes of importance:  Gastroenteritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1 year        |
|                                                                                | 111491,1000   | discreptive and the second sec | 1 year        |

V. S. No. 1 ä

state

| STA                                                                                                                             | TE OF      | MAR          | YLAND-                                  | CERTIFICATE OF DEATH                                                                                                                      |  |  |
|---------------------------------------------------------------------------------------------------------------------------------|------------|--------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. PLACE OF DEATH                                                                                                               | 22222 (30. |              |                                         | 80                                                                                                                                        |  |  |
| County Anne A                                                                                                                   |            |              |                                         | Registration Dist. No                                                                                                                     |  |  |
| Village Dr City                                                                                                                 |            |              | , (If                                   | death occurred in a hospital or institution, give its NAME instead of street and number)  ds. How long in U.S. if of foreign birth?yrsmos |  |  |
|                                                                                                                                 |            |              |                                         | 1011 1018 111 0111 01 1010 01                                                                                                             |  |  |
| 2. FULL NAME                                                                                                                    |            |              | Bessick                                 |                                                                                                                                           |  |  |
| (a) Residence: No.                                                                                                              | BaT.       | (Usual place | C1Ty                                    | St., Ward.  If nonresident give city or town and State                                                                                    |  |  |
| PERSONAL AND S                                                                                                                  | TATISTIC   |              |                                         | MEDICAL CERTIFICATE OF DEATH                                                                                                              |  |  |
| 3. SEX 4. COLOR OR black                                                                                                        |            |              | RIED, WIDOWED, D (write the word)       | 21. DATE OF DEATH June 15th (Month) (Day) (Yet                                                                                            |  |  |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                    |            |              |                                         | 22. I HEREBY CERTIFY, That I attended deceased May 10th 19 25 to June 15th 19                                                             |  |  |
|                                                                                                                                 | 1          | 908          |                                         | llast saw h im aliva on June 15th 19 35; death                                                                                            |  |  |
| 6. DATE OF BIRTH (month, day, and y 7. AGE Years                                                                                | Months     | Days         | If LESS than                            | to have occurred on the data stated above, at 2:30 A mill.                                                                                |  |  |
| 27                                                                                                                              | Unkno      |              | 1 day,hrs.<br>ormin.                    | The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:  Exhaustion due to mental  Date of                         |  |  |
| 8. Trade, profession, or particula kind of work dona, as SP                                                                     | NNER,      | None         |                                         |                                                                                                                                           |  |  |
| kind of work dona, as SP, SAWYER, BDOKKEEPER, et al. Industry or businass in which work was done, as SILK & SAW MILL, BANK, etc |            |              |                                         | disease                                                                                                                                   |  |  |
| 10. Data deceased last worked a this occupation (month and yaar)                                                                |            | spei         | ime (years)<br>nt in this ——<br>upation |                                                                                                                                           |  |  |
| 12. BIRTHPLACE (city or town)<br>(State or country)                                                                             | Maryl      | end          |                                         | Other Contributory Causes of Importanca: Dementia Praecox - katatonic type                                                                |  |  |
| a 13. NAME Harry                                                                                                                | Bessi      | ck, de       | ad                                      |                                                                                                                                           |  |  |
| 13. NAME Harry  14. BIRTHPLACE (city or town) (State or country)                                                                | Mary       | land         |                                         | Name of operation Data of Data of What test confirmed diagnosis? Was there an autopsy?                                                    |  |  |
| E 15. MAIDEN NAME EL                                                                                                            | a Tur      | ner          |                                         | 23. If death was due to external causes (VIOLENCE) fill in also the following:                                                            |  |  |
| 15. MAIDEN NAME Ell 16. BIRTHPLACE (city or town) (State or country)                                                            | 350        | ryland       |                                         | Accident, suicide, or homicide?                                                                                                           |  |  |
| 17 INFORMANT HO Spital                                                                                                          | Reco       | rds<br>e. ar | vland                                   | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                        |  |  |
| 18. BURIAL, CREMATION, OR REMOV                                                                                                 | AL .       |              | V-35,19                                 | Manner of injury                                                                                                                          |  |  |
| To UNDERTAKED Homo                                                                                                              | 181        | Kels         | on                                      | 24. Was disease or injury in any way related to occupation of deceased?                                                                   |  |  |
| (Addiess)/3/3-Re                                                                                                                | esman      | DA-B         | alderios he                             |                                                                                                                                           |  |  |
| 20. FILED \$ 12, 19                                                                                                             |            | 1074         | Registrar.                              | (Address) Crownsville, Maryland                                                                                                           |  |  |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

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| Example 1                                                                      | i             | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onsat |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
|                                                                                |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of Apportance:                                       | /             |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis 1035                                                           | 1 year        |
|                                                                                |               | 140                                                                            |               |
|                                                                                |               | 8/                                                                             |               |

V. S. No. 1

|                                                                    | S'                                                                                                                                             | TATE O                          | F MAR                 | YLAND-                                       | CERTIFICATE OF DEATH                                                                                                                   |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| 1                                                                  | PLACE OF DEAT                                                                                                                                  |                                 | 1 1 10                |                                              | <u>(£3)</u>                                                                                                                            |
|                                                                    | County Anne                                                                                                                                    | Arunde.                         | 1                     |                                              | Registration Dist. No.                                                                                                                 |
|                                                                    | Village or City                                                                                                                                | rownsvi                         | lle Stat              | te Hospit                                    | al No. St., Ward                                                                                                                       |
|                                                                    | Length of residence In cit                                                                                                                     |                                 |                       |                                              | death occurred in a hospital or institution, give its NAME instead of street and number)  25_ds. How long In U.S. if of foreign birth? |
| 2                                                                  | FULL NAME                                                                                                                                      | Eliza                           | Booe                  |                                              |                                                                                                                                        |
|                                                                    | (a) Residence: No                                                                                                                              | Baltim                          | ore City (Usual place | of abode)                                    | St, Ward.  If nonresident give city or town and State                                                                                  |
|                                                                    | PERSONAL AN                                                                                                                                    | D STATIST                       | CAL PARTI             | CULARS                                       | MEDICAL CERTIFICATE OF DEATH                                                                                                           |
| 3. S                                                               |                                                                                                                                                | r or race<br>lack               | OR DIVORCE            | RIED, WIDOWED,<br>D (write the word)<br>PIED | 21. DATE OF DEATH June 17th (Month) (Oay) (Year)                                                                                       |
| 5a.                                                                | If married, widowad, or divo                                                                                                                   | eter Bo                         | oe                    |                                              | January 22 19 34 to June 17th 19 35                                                                                                    |
|                                                                    | ATT OF BIRTH (month dos                                                                                                                        |                                 | 1874                  | ?                                            | I last saw h er alive on June 17th, 19 35 death is said                                                                                |
| 7. /                                                               | OATE OF BIRTH (month, day  AGE Years                                                                                                           | Months                          | Days                  | If LESS than                                 | to have occurred on the date stated above, atm.                                                                                        |
|                                                                    | 61?                                                                                                                                            | Unk                             | nown                  | 1 day,hrs.                                   | The PRINCIPAL CAUSE OF DEATH and related causes of importance ware as follows:                                                         |
| UPATION                                                            | 8. Trade, profession, or pa<br>kind of work done,<br>SAWYER, BOOKKEE<br>9. Industry or business in<br>work was done, as S<br>SAW MILL, BANK, & | PER, etc<br>which<br>SILK MILL, | Hous                  | sework                                       | General Paralysis of the Insahe                                                                                                        |
| ກວວດ                                                               | 10. Date deceased last wor<br>this occupation (more<br>year)                                                                                   | ked at                          | spe                   | Ime (years) nt in this upation               |                                                                                                                                        |
| 12.                                                                | BIRTHPLACE (city or town) (State or country)                                                                                                   | Mary.                           | land                  |                                              | Other Contributory Causes of Importance: Lues                                                                                          |
| 2                                                                  | 13. NAME Ric                                                                                                                                   | hard We.                        | lls                   |                                              |                                                                                                                                        |
| FATHER                                                             | 14. BIRTHPLACE (city or to<br>(State or country)                                                                                               | wn) Mar                         | yland                 |                                              | Name of operation Oate of What test confirmed diagnosis? What test confirmed diagnosis?                                                |
| ER                                                                 | 15. MAIOEN NAME                                                                                                                                | Rachae                          | LJones                |                                              | 23. If daeth was due to external causes (VIOL ENCE) fill in also the following:                                                        |
| MOTHER                                                             | 16. BIRTHPLACE (city or to<br>(State or country)                                                                                               |                                 |                       | ****                                         | Accident, sulcide, or homicide?                                                                                                        |
| Hospital Records 17. INFORMANT Crownsville, Maryland               |                                                                                                                                                |                                 |                       |                                              | (Specify city or town, county and State) Spacify whether Injury occurred In INOUSTRY, In HOME, or In PUBLIC PLACE.                     |
| 18. BURIAL, CREMATION, OR REMOVAL  Place Aurel Emoterne 6/00 19.35 |                                                                                                                                                |                                 |                       |                                              | Manner of injury                                                                                                                       |
| -                                                                  | UNOERTAKEN 120 1<br>(Address) 3 2 2<br>FILEO. 6 18                                                                                             | alse A                          | Jan                   | amo<br>mili-<br>milia                        | Nature of injury  24. Was disease or injury in any way related to occupation of deceased?  If so, specify  (Sign(d)                    |

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| Example I                                                                      | li            | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
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| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |
| Other contributory causes of importance:                                       | -             | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

| ADDITIONAL.           | SPACE    | FOR    | FURTHER      | STATEMENTS                                | RY   | PHYSICIA | N    |
|-----------------------|----------|--------|--------------|-------------------------------------------|------|----------|------|
| TELEVISION OF TAXABLE | DI ALCIA | T. OTF | T. CHETTITIE | D T 3 F T T T T T T T T T T T T T T T T T | 10 1 |          | 27.4 |

V. S. No. 1 N. B.—I

| STATE OF MARYLAND—                                                                                                                                               | CERTIFICATE OF DEATH 06263                                                                                                             |             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 1. PLACE OF DEATH                                                                                                                                                | (23)                                                                                                                                   |             |
| County Anne Arundel                                                                                                                                              | Registration Dist. No. 2/                                                                                                              | _           |
| Village or City Round Bay                                                                                                                                        | No. St., War- f death occurred in a hospital or institution, give its NAME instead of street and number)                               | d           |
| Length of residence in city or town where death occurred 16yrs mos                                                                                               | ds How long in U.S. if of foreign birth?yrsmosd                                                                                        | s.          |
| 2. FULL NAME Charles William Boone                                                                                                                               |                                                                                                                                        |             |
| (a) Residence: No. Round Bay, Md. (Usual place of abode)                                                                                                         | St., Ward.  If nonresident give city or town and State                                                                                 |             |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                             | MEDICAL CERTIFICATE OF DEATH                                                                                                           |             |
| 3. SEX 4. COLOR OR RACE White White  S. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) White                                                             | 21. DATE OF DEATH (Month) (Oay) (Year)                                                                                                 |             |
| 5a. If married, widowed, or divorced HUSBANO of (or) WIFE of Gertrude Bolander Boone                                                                             | 22 I HEREBY CERTIFY. That I attended deceased fro                                                                                      | _<br>m<br>_ |
| 6. DATE OF BIRTH (month, day, and year) May 20, 1872                                                                                                             | I last saw h alive on June 14, 1931; death is sai                                                                                      | id          |
| 7. AGE Years Months Days If LESS than                                                                                                                            | to have occurred on the date stated above, at                                                                                          |             |
| 63 25 1 day,hrs.                                                                                                                                                 | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                                         | t           |
| No. Frade, profession, or particular kind of work done, as SPINNER, Printer SAWYER, BOOKKEPER, etc.                                                              | Rulway Tuberenton ?                                                                                                                    | -           |
| kind of work done, as SPINNER, Printer SAWYER, BOOKKEEPER, etc.  9. Industry or business in which work was done, as SILK MILL, Proprietor of SAW MILL, BANK, etc |                                                                                                                                        | -           |
| 12. BIRTHPLACE (city or town) Anne Arundel County (State or country) Md.                                                                                         | Other Contributory Causes of importance:                                                                                               | 1           |
| Thomas C. Booner                                                                                                                                                 |                                                                                                                                        |             |
| 13. NAME Thomas C. Booner  14. BIRTHPLACE (city or town)  (State or country)  Md.                                                                                | Name of operation                                                                                                                      |             |
|                                                                                                                                                                  | What test confirmed diagnosis? Was there an autopsy? Q. 23. If death was due to external causes (VIOLENCE) fill in also the following: | pr. 44      |
| 15. MAIOEN NAME Mary A. Gambrill 16. BIRTHPLACE (city or town) Baltimore (State or country) Md.                                                                  | Accident, suicide, or homicide?                                                                                                        |             |
| 17. INFORMANT Edwin A. Fitzpatrick (Address) Abell Bldg., Balto., Md.                                                                                            | (Specify city or town, county and State) Specify whether injury occurred in INOUSTRY, In HOME, or in PUBLIC PLACE.                     |             |
| 18. BURIAL, CREMATION, OR REMOVAL Place Lorraine Cem. Oate June 17, 19 35                                                                                        | Manner of injury                                                                                                                       |             |
| 19. UNOERTAKER John O. Mitchell & Sons, Inc. (Address) 1900 Eutaw Place                                                                                          | If so, specify 15 1 2 1 2 1                                                                                                            |             |
| 20. FILED 15 , 1935 MORULTA Registrar.                                                                                                                           | (Signed) M. (Address) 20 E. Preston St.                                                                                                | D.          |

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| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL SP. | ACE | FOR | FURTHER | STATEMENTS | BY | PHYSICIAN |
|----------------|-----|-----|---------|------------|----|-----------|
|----------------|-----|-----|---------|------------|----|-----------|

STATE OF MARYLAND—CERTIFICATE OF DEATH OCCUPA 1. PLACE OF DEATH should Registration Dist. No. (If death occurred in a hospital or institution, give its NAME instead of street and number) How long in U.S. if of foreign birth? ... Length of residence in city or town where death occurred PHYSICIAN If nonresident give city or town and Sta Exact PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 5. SINGLE MARRIED, WIDOWED, 21. DATE OF DEATH Month) 5a. If married widowad, or divorced HUSBAND of CERTIFY. That I attanded deceased from (or) WIFE of 6. DATE OF BIRTH (month, day, and went) 7. AGE Months Devs If LESS than to have occurred on the date stated above, at 1 day .....hrs. The PRINCIPAL CAUSE OF DEATH and related causes of importance or\_\_\_\_min. 8. Trada, profassion, pr particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc..... O RESERVED may back 9. Industry or business in which work was done, as SILK MILL. SAW MILL, BANK, etc ... 10. Date daceasad last worked a 11. Total time (yaars) this occupation (month a that 12. BIRTHPLACE (city or town (State or country) FATHER 13. NAME See 14. BIRTHPLACE (city or town) Name of operation. plain (State or country) efully What test confirmed diagnosis? HER 15. MAIDEN NAME 23. If daeth was due to external causes (VIOLENCE) fill in also the following: MOTI Accident, suicide, or homicide?\_\_\_\_\_\_\_ Date of Injury\_\_\_\_\_\_ 19. 16. BIRTHPLACE (city or town) (State or country Where did injury occur?\_\_. (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE 17. INFORMANT Very OF (Address) 18. BURIAL CREMATION, OR REMOVAL Manner of injury CAUSE Nature of Injury. TION 24. Was disease or injury-in-any way ralated to occupation of deceased? 19. UNDERTA If so, specify egistrar. (Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

(Yaar)

Date of onset

(Day)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, took—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL S | SPACE | FOR | FURTHER | STATEMENTS | BY | PHYSICIAN |
|--------------|-------|-----|---------|------------|----|-----------|
|--------------|-------|-----|---------|------------|----|-----------|

V. S. No. 1 N. B.- of OCCUPA-

| STATE OF MARYLAND-                                                                                                                                                                                       | -CERTIFICATE OF DEATH 06265                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                        | 93-0                                                                                                                                              |
| County anne arrendel                                                                                                                                                                                     | Registration Dist. No.                                                                                                                            |
| Village or City Cumbratore                                                                                                                                                                               | No. St., Ward                                                                                                                                     |
| 1                                                                                                                                                                                                        | (If death occurred in a horpital or institution, give its NAME instead of street and number) osds. How long in U.S. if of foreign birth?yrsmosds. |
| 2. FULL NAME Rochel Br                                                                                                                                                                                   | ent                                                                                                                                               |
| (a) Residence: No. Cumbutou , h (Usual place of abode)                                                                                                                                                   | St., Ward.  If nonresident give city or town and State                                                                                            |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                     | MEDICAL CERTIFICATE OF DEATH                                                                                                                      |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Spice the word)                                                                                                                        | 21. DATE OF DEATH  (Month) (Day) (Year)                                                                                                           |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  Moses Breut                                                                                                                                | 22. I HEREBY CERTIFY, That I attended deceased from  19, 19, 35, to June 19, 19, 35                                                               |
| 6. DATE OF BIRTH (month, day, and year) and 16- 1883                                                                                                                                                     | I last sawh w aliva on not ab all 19 ; death is said                                                                                              |
| 7. AGE Years Months Days If LESS than 1 day,hrs                                                                                                                                                          | to have occurred on the date stated above, at                                                                                                     |
| 8. Trade, profession, or particular kind of work done, as SPINNER, House wife SAWYER, BOOKKEEPER, etc.                                                                                                   | acute myocarletis                                                                                                                                 |
| kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.  9. Industry or business In which work wes done, as SILK MILL, SAW MILL, BANK, etc.  10. Date deceased last worked at this securation (month and | •                                                                                                                                                 |
| 10. Date deceased last worked at this occupation (month end year) spant in this occupation                                                                                                               |                                                                                                                                                   |
| 12. BIRTHPLACE (city or town) a a co                                                                                                                                                                     | Other Contributory Causes of importance:                                                                                                          |
| 1 20 1 10                                                                                                                                                                                                | - Obesity                                                                                                                                         |
| 13. NAME Williams Frieds 1.  14. BIRTHPLACE (city or town) (Stete or country) Q. Q. Q. P. T.                                                                                                             | Name of operation Date of What test confirmed diagnosis? Was there an europsy?                                                                    |
| 15. MAIDEN NAME Ofullwood                                                                                                                                                                                | 23, If death was due to external causes (VIOL ENCE) fill in also the following:                                                                   |
| 15. MAIDEN NAME Officer  16. BIRTHPLACE (city or town)  (State or country)                                                                                                                               | Accident, suicide, or homicide? Date of injury, 19                                                                                                |
| 17. INFORMANT Moses Breat (Address) Combentone 20                                                                                                                                                        | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or In PUBLIC PLACE.                                |
| 18. BURIAL, CREMATION, OR REMOVAL Place Concern Chapter Date 20, 19                                                                                                                                      | Manner of injury                                                                                                                                  |
| 19. UNDERTAKER G A H T T T T T T T T T T T T T T T T T T                                                                                                                                                 | 24. Wes disease or injury in any wey related to occupation of deceased?                                                                           |
| 20. FILED 6/20, 1835 - H.A. Charton                                                                                                                                                                      | (Signed) Knig H- Inlan M. C<br>(Address) Lothica (M.S.                                                                                            |

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Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I Example II The principal cause of death and related causes Date of onset The principal cause of death and related causes | Date of onset of importance were as follows: of importance were as follows: 1915 Attack of epilepsy 1 week ago Arteriosclerosis 1921 Run over by street car 1 week ago Chronic interstitial nephritis Peritonitis 3 days ago Cerebral hemorrhage Julu 5.1927 Other contributory causes of importance: Other contributory causes of importance: Gastroenteritis 1 year May 1,1923 Gallstones

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| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                                                                                                                       |
|---------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1915          | Attack of epilepsy                                                             | 1 week ago                                                                                                                                          |
| 1921          | Run over by street car                                                         | 1 week ago                                                                                                                                          |
| July 5,1927   | Peritonitis                                                                    | 3 days ago                                                                                                                                          |
| 5 4 4         |                                                                                |                                                                                                                                                     |
|               | Other contributory causes of importance:                                       |                                                                                                                                                     |
| May 1,1923    | Gastroenteritis                                                                | 1 year                                                                                                                                              |
|               |                                                                                | 3)                                                                                                                                                  |
|               | 1915<br>1921<br>July 5,1927                                                    | of importance were as follows:  Attack of epilepsy  1921 Run over by street car  July 5, 1927 Peritonitis  Other contributory causes of importance: |

V. S. No. 1

| 1. PLACE                      | OF DEATH                                                                 |              |                         |                                      | in a                                                           |                      | 0.7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |
|-------------------------------|--------------------------------------------------------------------------|--------------|-------------------------|--------------------------------------|----------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| County                        |                                                                          | Aru:         |                         |                                      |                                                                | Registration         | Dist. No. 2]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                   |
| Village or                    | ,                                                                        | apoli        |                         | (If                                  | No. 207 Hanov                                                  | ation, give its NAMI | St.,<br>E instead of street as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Ward number)      |
| Length of r                   | asidence in city or tow                                                  | n where deat | th occurred             | yrs mos                              | ₹5 ds. How long in U.S. if o                                   | of foreign birth?    | yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _mosds.           |
| 2. FULL N                     | AME AUGI                                                                 | JSTA .       | A. BUR                  | WELL                                 | ones.                                                          | IN CORPORAT          | E LIMITS 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   |
| (a) Resid                     | ence: No. 207                                                            | Hano         | ver<br>(Usual place     | of abode)                            | St., Ward.                                                     | If nonresident       | give city or town a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | and State         |
| PERSO                         | NAL AND ST                                                               | ATISTIC      | AL PARTI                | CULARS                               | MEDICAL C                                                      | ERTIFICATE           | OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                   |
| 3. SEX                        | 4. COLOR OR R.                                                           | ACE 5        |                         | RIED, WIDOWED,<br>D (write tha word) | 21. DATE OF DEATH                                              | June                 | 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | , 193 3-5         |
| Temale<br>5e. If married, wid | lowad, or divorced                                                       |              | WIGOW                   | <u>ou</u>                            |                                                                | (Month)              | (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Yaar)            |
| HUSBAND of                    | Elliott                                                                  | H. Bu        | rwell,                  | Sr.                                  | 1 HEREB                                                        | Y CERTIF             | Y. That i attend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ed decaased from  |
| 6. DATE OF BIRT               | H (month, day, and yea                                                   | Fab          | . 11.                   | 1853                                 | i last saw h alive on                                          | June                 | 19.3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5.; death is said |
|                               | faers M                                                                  | onths        | Days                    | If LESS than 1 day,hrs.              | to have occurred on the date state. The PRINCIPAL CAUSE OF DEA |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| 1 0 7-11                      |                                                                          | 3            | 26                      | ormin.                               | ware as follows:                                               | Neman                | Lene                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Date of onest     |
| 8. Irada, pro                 | ofassion, or particular<br>of work dona, as SPIN<br>ER, BOOKKEEPER, etc. | NER,         | none                    |                                      | and you                                                        | 10000                | The same of the sa | 0-16/34           |
| 9. Industry                   | r business in which                                                      |              |                         | *******                              | ~                                                              |                      | {/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |
|                               | wes dona, as SILK MII<br>MILL, BANK, atc                                 | .L,          |                         |                                      |                                                                |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| O this or                     | aased last worked at<br>ecupation (month and                             |              | spa                     | ima (years)<br>nt in this<br>upation |                                                                |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| 12. BIRTHPLACE                | (eity or town)                                                           |              |                         |                                      | Othar Contributory Causes of imp                               | ortance: Sed         | end                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6-1-30            |
| (State or o                   |                                                                          | Mary         | land.                   |                                      |                                                                | 4./                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| 13. NAME                      | Augustu                                                                  | s Sol        | lers                    |                                      |                                                                |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| I 14. BIRTHPLA                | ACE (city or town)                                                       |              |                         |                                      | Name of oparation                                              |                      | Date o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | f                 |
| (State                        | or country)                                                              | Ma           | ryland                  | •                                    | What test confirmed diegnosis?                                 |                      | Wes there a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | an autopsy?       |
| 15. MAIDEN                    | NAME Rebec                                                               | ca So        | mervil                  | le                                   | 23. If death was due to external ca                            | uses (VIOLENCE) fi   | Il In also the follow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ving:             |
| 16. BIRTHPLA                  | ACE (city or town)                                                       |              |                         |                                      | Accident, suicida, or homicide?                                |                      | Date of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | , 19              |
| (State or country) Maryland.  |                                                                          |              | Where did injury occur? | (Someiles eiter on                   | town, county and                                               | State                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| 17. INFORMANT (Addrass)       | Elliott Hanover                                                          | H. Bu        | rwell.                  | Jr.<br>lis Md.                       | Specify whathar injury occurred in                             | in INDUSTRY, in HO   | OME, or in PUBLIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | PLACE,            |
| 18. BURIAL, CREN              | ation, or removal<br>est River                                           |              |                         | Ann                                  | Mannar of injury                                               |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
|                               | John M.<br>Annapoli                                                      |              |                         |                                      | 24. Wes disaase or injury in any v                             |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| 20. FILED.                    | 7, 19. 2                                                                 | 4.           |                         |                                      | (Signad) Walfa                                                 | n HH                 | offsin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ne d M. E         |
|                               |                                                                          |              |                         | Registrar.                           | (Address)                                                      | wasy                 | of less 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | no                |

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10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       | May 1,1923    | Other contributory causes of importance:                                       |               |
|                                                                                | Muy 1,1925    | dastroenterus                                                                  | 1 year        |

| ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICI | ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PR | IYSICIAI |
|----------------------------------------------------|-----------------------------------------------|----------|
|----------------------------------------------------|-----------------------------------------------|----------|

|             | Registration Dist. No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | /                                       |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| (11 c       | No. St.,    St.   St. |                                         |
| 200         | Campbelleteran specify WAR Mont                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |
| ru.         | St. N.W. Ward.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |
| W           | as hing tou D. C. If nonresident give city or town and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | State                                   |
|             | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
| ED,<br>rd)  | 21. DATE OF DEATH  (Month) (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 193_5<br>(Year)                         |
|             | 22. I HEREBY CERTIFY, That I ettended of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | leceased from                           |
|             | , 19, to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | , 19                                    |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ; death is seld                         |
| han<br>hrs. | to have occurred on the date stated above, et                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |
| 1.          | The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Date of onset                           |
|             | a boat was invalved. Cross P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |
|             | December fell oversounds from open touts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         |
| my          | Tehelo Frahing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |
| 1           | Water , what three freti des for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |
|             | Other Contributory Causes of Importance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                         |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |
|             | accedental Death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |
|             | ley During                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |
| la          | Name of peration Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | *************************************** |
| u           | What test confirmed diagnosis? Was there an a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |
|             | 23. If death wes due to external causes (VIOL ENCE) fill in also the following                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |
|             | Accident, suicide, or homicide? Gcoulents. Date of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | , 19                                    |
|             | Where did injury occur?(Specify city or town, county and State Specify whether injury occurred in INDUSTRY, in HOME, or In PUBLIC PL/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ACE.                                    |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |
| 35          | Manner of injury Accidental Arowning                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |
| 9-2-2       | Nature of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         |
|             | 24. Was disease or injury in any way related to occupation of deceased?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         |
|             | (Signed) Word S. Muult                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |
| rar.        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | WY.                                     |
| - 60 7 1    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I                                                                      |               | Example II                                                                     |               |  |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|--|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |  |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |  |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |  |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |  |
|                                                                                |               |                                                                                |               |  |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |  |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |  |
|                                                                                |               |                                                                                |               |  |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

Date of onset

. Was thara an autopsy?\_>L4

BINDING

RESERVED

MARGIN

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1931          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage 1 11 29 130                                                | July 5, 1927  | Peritonitis                                                                    | 3 days ago    |
| A. A.                                                                          |               |                                                                                |               |
| Other contributory causes of importance.                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

V. S. No. 1

| STATE OF MARYLAND—                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (59)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| County and arundel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Registration Dist. No. 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Village or City Cumberstone P.O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NoSt., Ward                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Length of residence in city or town where death occurred 35 yrs. A5 mos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | death occurred in a hospital or institution, give its NAME instead of street and number) ds. How long in U.S. if of foreign birth?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 2. FULL NAME (In 1 (ornelia Murr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ay Colhoun.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| (a) Residence: No. Gemberstone, md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | St. Ward.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | If nonresident give city or town and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 3. SEX  4. COLOR OF RACE OR DIVORCED (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 21. DATE OF DEATH  (Month)  (Dey)  (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5a. If merried, widowed, or divorced HUSBAND of Charles Murroy Ofhacus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 22. I HEREBY CERTIFY. That I attended deceased from 1935, to 100 10 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 6. DATE OF BIRTH (month, day, and yeer) Lept 8-11857                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 last seph en ellve on 1111/10 1935; death is said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 7. AGE Years Months Deys If LESS then 1 day,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | to have occurred on the date stated above, et/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 8. Trede, profession, or particular kind of work done, es SPINNER, Abousevefo SAWYER, BOOKKEEPER, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Phillmonia to runchea Juni 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Kind of work done, es SPINNER, Available of Work done, es SPINNER, Available of Work done, es SPINNER, Available of Work was done, es SILK MILL, SAW MILL, BANK, etc  10. Date deceased last worked et this occupation (month end spant in this compation of month end spant in this compation of the span of the |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10. Date deceased last worked et this occupation (month end yeer)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Con la la la la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Other Contributory Causes of importance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| (Stete or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | The the transfer of the state o |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Cit Len is 50 Consti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 13. NAME Henry Mayradia Murray 14. BIRTHPLACE (city or town) Elkin age                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Neme of operation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| (Stete of Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What test confirmed diagnosis? Wuse Medad Was there en eulopsy?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 15. MAIDEN NAME Wary Abellinger of Boves 16. BIRTHPLACE (city or town) Duela.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23. If deeth was due to external causes (VIOLENCE) fill In elso the following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 16. BIRTHPLACE (city or town) Quela.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Accident, sulcide, or homicide?Date of injury, 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| (State or country) / emaylvaries                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Where did injury occur? (Specify city or town, couoty and State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 17. INFORMANT Muss U. (" Musson") The (Address) Cember of one The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 18. BURIAL, CREMATION, OR REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Manner of Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Place Illas Ville, 1. 11 Date June 11 , 1933                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Neture of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 19. UNDERTAKER Thu M. Laylor (Address) Cumapales mid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 24. Was disease or injury In any way releted to occupetion of deceased?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 20. FILED 6-10, 1935 MING Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Signed) Walter Hanso M.D.  (Address) Survey of the MA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If more blanks are needed, address State Registrar,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2411 N. Charles Street, Balsimore, Requesting V. S. No. 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Perilonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL | SPACE | FOR | FURTHER | STATEMENTS | BY | PHYSICIAN |
|------------|-------|-----|---------|------------|----|-----------|
|------------|-------|-----|---------|------------|----|-----------|

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# STATE OF MARYLAND—CERTIFICATE OF DEATH

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| U | 0 | 4 | 7     | 1 |

| 1. PLACE                                                                                                                  | OF DEATH                                                         |                                       |                                | (23)                                                                                                                                                                                       | 1447                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| County                                                                                                                    | Anne Arunde                                                      | 1                                     |                                | Registration Dist. No. 22                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|                                                                                                                           | City Jessup,                                                     |                                       | yrs, 9 (I                      | NoMaryland House of Correct fideath occurred in a hospital or institution, give its NAME instead of street as 26 ds. How long in U. S. if of foreign birth?                                | leadens be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
|                                                                                                                           | AME Leon C.                                                      | Conley  926 D                         | ruid Hill &                    | Not knownif veteran  Yest, Ward. Baltimore Ma                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| PERSO                                                                                                                     | NAL AND STATIS                                                   | (Usual place                          |                                | If nonresident give city of town  MEDICAL CERTIFICATE OF DEATH                                                                                                                             | The state of the s |  |
| 3. SEX<br>Male                                                                                                            | 4. COLOR OR RACE<br>Colored                                      | 5. SINGLE, MARI                       | RIED, WIDOWED,                 | 21. DATE OF DEATH June-27-1935 (Month) (Day) (Year)                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 5a. If married, wid<br>HUSBAND of<br>(or) WIFE of                                                                         | owed, or divorced  Madeline (                                    | Conley                                |                                | 22. I HEREBY CERTIFY, Thet I altend<br>May-22-1935 19 to June-27-1                                                                                                                         | led deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 7. AGE Y                                                                                                                  | 4 (month, dey, and year) ears Months 36 7 fession, or particular | November Days 14                      | If LESS than 1 day,hrs. ormin. | B I last sew him alive on June-27-1935 <sub>19</sub> to have occurred on the date stated above, at 1:50 P.M The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: | Date of onset                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| 9. Industry o work v SAW N                                                                                                | work done, as SPINNER, R, BOOKKEPER, etc                         | Lukuowi<br>11. Totel ti<br>kuowi norm | me (years) It in this pation   | Plumonary Tuberculosis<br>With Effusions                                                                                                                                                   | ?<br>6-8 <b>-3</b> 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| 12. BIRTHPLACE ( (State or co                                                                                             | city or town) Balti                                              |                                       | pation                         | Cardiac Decompensation  Myocardial Failure                                                                                                                                                 | 6-26-3<br>6-27-3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| (State                                                                                                                    | CE (city or town)                                                | uknowu                                | <u> </u>                       | Name of operation None Date of What test confirmed diagnosis? Clinical Findingautopsy? No                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 15. MAIDEN NAME Mary Duckins  16. BIRTHPLACE (city or town) cere known  (Slate or country)  17. INFORMANT Attury Affricas |                                                                  |                                       | oww                            | 23. If death wes due to external causes (VIOLENCE) fill In elso the following:  Accident, suicide, or homicide?                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| (Address) 18. BURIAL, CREM. Place                                                                                         | ATION, OR BEMOVAL                                                | Balto I                               | and 1,135                      | Manner of Injury                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 19. UNDERTAKER<br>(Address)<br>20. FILED                                                                                  | 1303 Pres<br>28,135 los                                          | stimes<br>ara le H                    | m extraction assured           | 24. Was disease or injury in any way related to occupation of deceased?  If so, specify  (Signed) Lower Lower Maryland  (Address) Jessup Maryland                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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9.—The industry or business in which the work was done.

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Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

|               | Example II                                                                     |                                                                                                                                                                                                                    |
|---------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                                                                                                                                                                                      |
| 1915          | Attack of epilepsy                                                             | 1 week ago                                                                                                                                                                                                         |
| 1921          | Run over by street car                                                         | 1 week ago                                                                                                                                                                                                         |
| July 5,1927   | Peritonitis                                                                    | 3 days ago                                                                                                                                                                                                         |
|               | Other contributory causes of importance:                                       |                                                                                                                                                                                                                    |
| May 1,1923    | Gastroenteritis                                                                | 1 year                                                                                                                                                                                                             |
|               |                                                                                |                                                                                                                                                                                                                    |
|               | 1915<br>1921<br>July 5,1927                                                    | Date of onset  The principal cause of death and related causes of importance were as follows:  Attack of epilepsy  1921 Run over by street car  July 5, 1927 Peritonitis  Other contributory causes of importance: |

# STATE OF MARYLAND-CERTIFICATE OF DEATH

| 1. PLACE OF DEATH                                                                                  | <u> </u>                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| County ann arm                                                                                     | Registration Dist. No. 40                                                                                                                                         |
| Village or City Harring  Length of residence in city or town where death occurred                  | ND. St., War (If death occurred in a horpital or institution, give its NAME instead of street and number)  105. How long in U.S. if of foreign birth? yrs. mos. d |
| 2. FULL NAME (log) Creek.                                                                          |                                                                                                                                                                   |
| (a) Residence: No. (Usual place of abode)                                                          | St., Ward.  If nonresident give city or town and State                                                                                                            |
| PERSONAL AND STATISTICAL PARTICULARS                                                               | MEDICAL CERTIFICATE OF DEATH                                                                                                                                      |
| 3. SEX 4. COLOR OR RACE OR DIVORCED (write the word)                                               | 21. DATE OF DEATH  (Month) (Day) (Year)                                                                                                                           |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                       | 22. I HEREBY CERTIFY. That I attended daceased from                                                                                                               |
| 6. DATE OF BIRTH (month, day, and year) June 17, 1935                                              | I last sawh emalive on not at all , 19 ; death is so                                                                                                              |
| 7. AGE Years Months Days If LESS than 1 day,h orh                                                  |                                                                                                                                                                   |
| 8. Trade, protession, or particular kind of work dona, as SPINNER, SAWYER, BODKKEEPER, etc         | Stillborn                                                                                                                                                         |
| work was done, as SILK MILL, SAW MILL, BANK, etc                                                   |                                                                                                                                                                   |
| O this occupation (month and spent in this occupation                                              | Dthar Contributory Causes of Importance:                                                                                                                          |
| 12. BIRTHPLACE (city or town) (State or country)                                                   | Syphilis                                                                                                                                                          |
| 13. NAME genge uncland                                                                             | III                                                                                                                                                               |
| 14. BIRTHPLACE (city or town) Q. Q. Q. Weenly (State or country)                                   | Name of operation Date of Was there an autopsy?                                                                                                                   |
| 15. MAIDEN NAME July I da Creck-                                                                   | 23. If death was due to external causes (VIOL ENCE) fill in also the following:                                                                                   |
| 15. MAIDEN NAME way I do Creek -  16. BIRTHPLACE (city or town) a. a. county -  (State or country) | Accident, suicida, or homicida?                                                                                                                                   |
| 17. INFORMANT Scoulage Moreland Harmod Mark                                                        | (Specify city or town, county and State) Specify whether Injury occurred in INDUSTRY, in HOME, or In PUBLIC PLACE.                                                |
| 18. BURIAL, CREMATION, DR REMOVAL Drugg 6/17, 192                                                  | Manner of Injury                                                                                                                                                  |
| 19. UNDERTAKER Glorge Moreland                                                                     | 24. Was disease or injury In any way related to occupation of deceased?                                                                                           |
| 20. FILED 6/17, 1025 - 11 A Clay to                                                                | (Signed) Loudy H. hulson M (Address) Lottures ( hud                                                                                                               |

V. S. No. 1

stated EXACTLY. PHYSICIANS should state

Exact statement of OCCUPA-

properly classified.

N. B.-WRITE PLAINLY, WITH UNFADING INK-THIS IS A PERMANENT RECORD. Every item of infor-

cause of DEATH in plain terms, so that it may be

FOR BINDING

MARGIN RESERVED

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was donc.
10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," ctc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

| Ex                                                      | ample I                   |               | Example II                                                                     |               |
|---------------------------------------------------------|---------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of dear of importance were as follo | th and related causes ws: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                        |                           | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                          | THE TOTAL SECTION         | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                     |                           | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
|                                                         | WORALL V.                 |               |                                                                                |               |
| Other contributory causes                               | of importance:            |               | Other contributory causes of importance:                                       |               |
| Gallstones                                              |                           | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                         |                           |               |                                                                                |               |
|                                                         |                           |               |                                                                                |               |

| ADDITIONAL | SPACE   | FOR    | FURTHER     | STATEMENTS       | RY   | PHYSICIA | N  |
|------------|---------|--------|-------------|------------------|------|----------|----|
| THEFT      | DI AULI | T. OIL | T OILLIILII | DIATERIALIZATION | 10 1 | THISTOIN | LΠ |

state

N. B.-WRITE PL.

# STATE OF MARYLAND-CERTIFICATE OF DEATH

| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| County ly la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Registration Dist. No.                                                                                             |
| Village or City and the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | No. 10 Thompsein St., Ward                                                                                         |
| (II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | death occurred in a hospital or institution, give its NAME instead of street and number)                           |
| Length of residence in city or town where death occurredyrsmos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ds. How long in U.S. if of foreign birth?                                                                          |
| 2. FULL NAME Clubeth WW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | elf.                                                                                                               |
| (a) Residence: No. 143 South                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | St., Ward.                                                                                                         |
| (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | If nonresident give city or town and State                                                                         |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MEDICAL CERTIFICATE OF DEATH                                                                                       |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21. DATE OF DEATH                                                                                                  |
| Femals! Car, married.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Month) (Day) (Yeer)                                                                                               |
| 5d. If married, widowed, or divorced HUSBAND of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                    |
| (or) WIFE of James Worlder.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | HEREBY CERTIFY, Thet I ettended deceased from                                                                      |
| 6. DATE OF BIRTH (month, day, and year) May, 12 - 11889                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | I last saw h & elive on 19 deeth is said                                                                           |
| 6. DATE OF BIRTH (month, day, and year) \\ \( \mathcal{L} = \) \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | to heve occurred on the date stated above, at 120 m.                                                               |
| 1 day,hrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | The PRINCIPAL CAUSE OF DEATH end releted causes of importence                                                      |
| 8 Trade profession or particular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | were as follows:                                                                                                   |
| Kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (10.1)                                                                                                             |
| 9. Industry or business in which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | The last                                                                                                           |
| work was done, as SILK MILL, SAW MILL, BANK, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Primary Course: Lastro-enterities Curer                                                                            |
| 10. Date deceased last worked et this occupation (month end spent in this                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                    |
| year) occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Duration: three hours                                                                                              |
| 12. BIRTHPLACE (city or town) Proach Nect.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Other Contributory Causes of Importance:                                                                           |
| (State or country) (D) - (W) Cu > md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Arns                                                                                                               |
| 13. NAME John mond                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                    |
| 13. NAME 114. BIRTHPLACE (city or town) Declarate 14. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Name of operation Date of                                                                                          |
| (State or country) a - a - co - md .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What test confirmed diagnosis? Was there an eu'opsy? No                                                            |
| 15. MAIDEN NAME Julen Cul,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 23. If death was due to external causes (VIOLENCE) fill in also the following:                                     |
| 15. MAIDEN NAME  16. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Accident, suicide, or homicide? Date of Injury, 19                                                                 |
| (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Where did injury occur?                                                                                            |
| James Willedon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or In PUBLIC PLACE. |
| 17. INFORMANT (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Specify whether impary occurred in Habostki, in Home, of in Public Place.                                          |
| 18. BURIAL, CREMATION, OR REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Menner of injury                                                                                                   |
| Place Quel lel Dete June 16, 1935.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Nature of injury                                                                                                   |
| De la Companya de la |                                                                                                                    |
| 19. UNDERTAKER (Address)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 24. Was disease or injury in any wey related to occupation of deceased?                                            |
| 6/14 26 11/11/11/11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Signed) MAD                                                                                                       |
| 20. FILED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (Address)                                                                                                          |
| If more blanks are needed address State Projects                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (Audiess)                                                                                                          |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

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In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis .                                                             | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PI |
|-----------------------------------------------|
|-----------------------------------------------|

|         | A-                                             | STATE OF MARY                                                                                                                                                                        | LAND-                      | CERTIFICATE OF DEATH 062                                                            | 74              |
|---------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------|
| (4)     | state<br>UPA-                                  | 1. PLACE OF DEATH                                                                                                                                                                    |                            | 159                                                                                 | 0 3.            |
|         | occi of                                        | County 6. Co                                                                                                                                                                         |                            | Registration Dist. No.                                                              | /               |
|         | = = \                                          | Village or City Kwe Kaben -                                                                                                                                                          | aug 6                      | 18 Marshell Co - Med. St                                                            | Ward            |
| (1)     |                                                |                                                                                                                                                                                      | (If                        | death occurred in a hospital or institution, give its NAME instead of street and no | umber)          |
|         | Every<br>MANS<br>Ement                         | Length of residence in city or town where death occurred                                                                                                                             | yrsmos.                    | ds. How long in U.S. if of foreign birth?yrsmos                                     | sds.            |
| P       | D. Every<br>SICIAN<br>tatement                 | 2. FULL NAME Killy Sulf                                                                                                                                                              | fall                       | Mulalul at 6 les.                                                                   |                 |
| -       | RD. Every<br>YSICIANS<br>statement             | (a) Residence: No. Dure Maker                                                                                                                                                        | -a6                        | (So, WWard.                                                                         | _               |
|         |                                                | (Usual place of                                                                                                                                                                      |                            | If nonresident give city or town and S                                              | State           |
|         | PF<br>PF<br>xact                               | 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRI                                                                                                                                             |                            | MEDICAL CERTIFICATE OF DEATH                                                        |                 |
|         | Y. E                                           | OR DIVORCED                                                                                                                                                                          | (write the word)           | 21. DATE OF DEATH                                                                   | 1025            |
| 5       | T L ed.                                        | Sa If married widowed or divorced                                                                                                                                                    | ye                         | (Month) (Day)                                                                       | (Year)          |
| Z       | A C T ssifted                                  | 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of  WALLE                                                                                                                  | 1                          | 22. I HEREBY CERTIFY, That I attended d                                             | deceased from   |
| BINDI   |                                                | 7                                                                                                                                                                                    | 1/2 1                      | Men (8 , 1921, to June 18                                                           | -, 19 31        |
| BII     | inter a                                        | 6. DATE OF BIRTH (month, day, and year) Here!                                                                                                                                        | 1431                       | I last saw hala alive on the of 1975                                                | ; death is said |
| 23      | IS A PE<br>stated E<br>properly<br>certificate | 7. AGE Years Months Days                                                                                                                                                             | If LESS than I day, 2 hrs. | to have occurred on the date stated above, at                                       |                 |
| FO      | IS A<br>state<br>prop                          |                                                                                                                                                                                      | ormin.                     | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:      | Date of onact   |
| 0       | 70                                             | 8. Trade, profession, or particular kind of work done, as SPINNER                                                                                                                    | 1 1=                       | 1-14                                                                                | Date of bilaet  |
| Œ       | THIS<br>be<br>be<br>c of                       | o. Irade, profession, or particular kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc.  9. Industry or business in which                                                        | the                        | Mualine at 6 les                                                                    | Janel           |
| RV      | K-T<br>hould<br>may<br>back                    | 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc 11. Total time his occassed last worked at his occassed last worked at his occassed last worked at | cr o aux                   |                                                                                     | forly           |
| 国       | INK sho                                        | 1D. Date deceased last worked at this occupation (month and spent                                                                                                                    | e (years) /                |                                                                                     | 1191            |
| RESERVE |                                                | occupation (month and year) spent occupa                                                                                                                                             | in this Made               |                                                                                     |                 |
|         | NFADING pplied. AGI erms, so tha instructions  | 12. BIRTHPLACE (city or town) - June State -                                                                                                                                         | 46.60                      | Other Contributory Causes of importance:                                            |                 |
| H       | AD dd.                                         | (State or country)                                                                                                                                                                   | 4C Il                      | Kere                                                                                |                 |
| R       | NF<br>plie<br>rm<br>nst                        | 13. NAME Bradly Columbus                                                                                                                                                             | 1 face                     |                                                                                     |                 |
| MARGIN  | D = 0                                          | 13. NAME Mady Columbus  14. BIRTHPLACE (city or town) funt to be referenced.                                                                                                         |                            | Name of operation                                                                   |                 |
|         | TO                                             | (State or country)                                                                                                                                                                   | Here                       | What test confirmed diagnosis? - fleulliss Was there an au                          | topsy?llw       |
|         | Y, WTTP<br>carefully<br>TH in pla<br>ortant.   | 15. MAIDEN NAME Surary Centra                                                                                                                                                        | tale                       | 23. If death was due to external causes (VIOLENCE) fill in also the following:      |                 |
|         | LY, W<br>careful<br>(TH in p                   | 6 16. BIRTHPLACE (city or town) - Stat A Reser                                                                                                                                       |                            | Accident, suicide, or homicide? Date of injury                                      | , 19            |
|         | AT AT                                          | (State or country)                                                                                                                                                                   | C. Wy                      | Where did injury occur?                                                             |                 |
|         | 一口口,口                                          | 17. INFORMANT Susher Livery Stall                                                                                                                                                    |                            | (Specify city or town, county and State in INDUSTRY, In HOME, or in PUBLIC PLAI     | CE.             |
|         | Should OF D                                    | (Address) your statem                                                                                                                                                                | -11.4 th                   | ļ                                                                                   |                 |
|         | Sh Sh is 'si                                   | 18. BURIAL, CREMATION, OR REMOVAL  Place Flancisco Date fund                                                                                                                         | 18                         | Manner of injury                                                                    |                 |
|         | -WRITE<br>mation s<br>CAUSE<br>TION is         | Place Figure Date Date                                                                                                                                                               | 19.7                       | Nature of injury                                                                    |                 |
| -       | mation<br>CAUS<br>TION                         | 19. UNDERTAKER Thomas 19. English                                                                                                                                                    | man Hell                   | 24. Was disease or injury in any way related to occupation of deceased?             | W               |
| Z.      | B                                              | (Address) Jun O. Mil                                                                                                                                                                 | 4                          | If so, specify                                                                      |                 |
| ρ.      | z U                                            | 20. FILED 6 1 19 3 5                                                                                                                                                                 | Inco?                      | (Signed)                                                                            | M. D.           |
|         |                                                |                                                                                                                                                                                      | Registrar.                 | (Address)                                                                           | 4               |
|         |                                                | If more blanks are needed, add                                                                                                                                                       | iress State Registrar, 2   | 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.                          |                 |

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
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| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week age    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of infor-

MARGIN RESERVED FOR BINDING

V. S. No. 1

| STATE OF MARYLAND—                                                                                                                        | CERTIFICATE OF DEATH                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                                                         | 06275                                                                                                                                       |
| County                                                                                                                                    | Registration Dist. No.                                                                                                                      |
| Village or City Specimol.                                                                                                                 | No. St., Ward                                                                                                                               |
| (If Langth of residenca In city, or town where death occurredyrsmos                                                                       | death occurred in a hospital or institution, give its NAME instead of street and number) ds. How long in U.S. if of foreign birth?yrsmosds, |
| 2. FULL NAME Sevige Alked                                                                                                                 | Tasses                                                                                                                                      |
| (a) Residence: No. Shidmore                                                                                                               | St. Ward.                                                                                                                                   |
| (Usual place of abode)                                                                                                                    | If nonresident give city or town and State                                                                                                  |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                      | MEDICAL CERTIFICATE OF DEATH                                                                                                                |
| 3. SEX 4. COLOR OR RACE OR DIVORCED (write the word)  Or Divorced (write the word)                                                        | 21. DATE OF DEATH (Month) (Day) (Year)                                                                                                      |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                                              | 22. I HEREBY CERTIFY, That I ettended deceased from                                                                                         |
| 7                                                                                                                                         | may 25 1935, to grave 1, 1935                                                                                                               |
| 6. DATE OF BIRTH (month, day, end yeer) July 11 1887                                                                                      | I last saw h 1 3 aliva on 1925; death is sald                                                                                               |
| 7. AGE Years Months Days If LESS than 1 day,hrs. ormin.                                                                                   | to have occurred on the date stated above, at 2                                                                                             |
| 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.                                               | D. A.                                                                                                                                       |
| kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.  9. Industry or business in which work was done, as SILK MILL, SAW MILL BANK etc. | 12. Millimma (Ilsmost fray 2)                                                                                                               |
| work was done, as SILK MILL,<br>SAW MILL, BANK, etc.                                                                                      |                                                                                                                                             |
| Date deceased last worked at this occupation (month and spant in this                                                                     |                                                                                                                                             |
| year) occupation                                                                                                                          | Other Contributory Causes of Importence:                                                                                                    |
| 12. BIRTHPLACE (city or town) African (State or country)                                                                                  | Lydrocephalis                                                                                                                               |
| 13. NAME Alfred Hulres                                                                                                                    | The Callatine Contraction                                                                                                                   |
| 13. NAME ALCO KULLOS  14. BIRTHPLACE (city town) Shadana                                                                                  | Name of operation                                                                                                                           |
| (State of County)                                                                                                                         | What test confirmed diagnosis? Was there an autopsy                                                                                         |
| 15. MAIDEN NAME PLAKING BUNGS  16. BIRTHPLACE (city or town) Spedmore  (State or country)                                                 | 23. If deeth was due to extornal causes (VIOLENCE) fill in also the following:                                                              |
| 5 16. BIRTHPLACE (city or town) Spannoc                                                                                                   | Accident, suicide, or homicide?Date of Injury, 19                                                                                           |
| State or country)                                                                                                                         | Where did injury occur? (Specify city of town, county and State)                                                                            |
| 17. INFORMANT Clands Value (Address) Speamore                                                                                             | Specify whether injury occurred In INDUSTRY, in HOME, or In PUBLIC PLACE.                                                                   |
| 18. BURIAL, CREMATION, OR REMOVAL                                                                                                         | Manner of Injury                                                                                                                            |
| Place / MacMich Date Price 4 , 1925                                                                                                       | Nature of Injury                                                                                                                            |
| 19. UNDERTAKER 3. Amagina                                                                                                                 | 24. Was disease or injury In any way related to occupation of deceesed?                                                                     |
| 20. FILED 6 3 ,19.35 Registrar.                                                                                                           | (Signed) // Musey to Mawans M. D. (Address) 4 6 5 mm (4 th law)                                                                             |
| If more blanks are needed, address State Registrar,                                                                                       | 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.                                                                                  |

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Example I Example II The principal cause of death and related causes The principal cause of death and related causes Date of onset Date of onset of importance were as follows: of importance were as follows: Arteriosclerosis 1915 Attack of epilensu 1 week ago Chronic interstitial nephritis 1921 Run over by street car 1 week ago Cerebral hemorrhage July 5, 1927 Perilmitis 3 days ago Other contributory causes of importance: Other contributory causes of importance: Gallstones May 1.1923 Gastroenteritis 1 year

| ADDITIONAL | SPACE F | OR FURTHER | STATEMENTS | BY | PHYSICIAN |
|------------|---------|------------|------------|----|-----------|
|------------|---------|------------|------------|----|-----------|

|                                                                                    |                                       | F MAR                                | YLAND-                            | CERTIFICATE OF DEATH                                                                                                            | 06276                            |  |
|------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|
| 1. PLAGE OF                                                                        | Anne Arun                             | lah                                  |                                   | (83)                                                                                                                            | 4.1                              |  |
| County                                                                             |                                       |                                      |                                   | Registration Dist. N                                                                                                            |                                  |  |
| Village or City_                                                                   | Crownsvi.                             | Lle Sta                              | te Hospi                          | death occurred in a horpital or institution, give its NAME instead                                                              | of street and number)            |  |
| Length of residen                                                                  | ce in city or town where de           | ath occurred1                        | yrsmos                            | 23. How long in U.S. if of foreign birth?y                                                                                      | sds.                             |  |
| 2. FULL NAME                                                                       | E Theo                                | dore Ha                              | wkins                             |                                                                                                                                 |                                  |  |
| (a) Residence:                                                                     | No. Malc                              | Olm, Ch<br>(Usual place              | arles Cor                         | untsy., Mawal and If nonresident give city                                                                                      | or town and State                |  |
| PERSONAL                                                                           | L AND STATISTIC                       | CAL PARTI                            | CULARS                            | MEDICAL CERTIFICATE OF                                                                                                          | DEATH                            |  |
| male                                                                               | black                                 | 5. SINGLE, MAR<br>OR DIVORCE<br>Sing | RIED, WIDOWED, D (write the word) | 21. DATE OF DEATH  June 20th  (Month)                                                                                           | , 193.5<br>ey) (Year)            |  |
| 5a. If married, widowed,<br>HUSBANO of                                             | or divorced                           |                                      |                                   | 22. I HEREBY CERTIFY, Tha                                                                                                       | t I attended deceased from       |  |
| (or) WIFE of                                                                       |                                       |                                      |                                   | May 28th 1934 10 June                                                                                                           | 20th , 19 35                     |  |
| 6. DATE OF BIRTH (mo                                                               | nth, day, end yeer)                   | 906 (?)                              |                                   | last saw him elive on June 20th                                                                                                 |                                  |  |
| 7. AGE Yeers 27                                                                    | (?) Months Unkno                      | Days<br>WN                           | If LESS than  1 day,hrs.  ormin.  | to heve occurred on the date steted above, et6 . 4 Q_m, The PRINCIPAL CAUSE OF DEATH and releted causes of imperent as follows: |                                  |  |
| 8. Trede, professio                                                                | n, or perticuler                      |                                      |                                   | General paralysis of the                                                                                                        | 2                                |  |
| SAW MILL, I                                                                        | k done, es SPINNER,<br>DKKEEPER, etc. | Unkno                                | wa                                | Insane                                                                                                                          | ?                                |  |
| work was do                                                                        | one, es SILK MILL,<br>BANK, etc       |                                      |                                   |                                                                                                                                 |                                  |  |
|                                                                                    |                                       | spa                                  | ime (yeers) nt in this            |                                                                                                                                 |                                  |  |
| 12. BIRTHPLACE (city of (State or country)                                         | r town)                               | nown                                 |                                   | Dther Coutributory Causes of importance: LUC S                                                                                  |                                  |  |
| 13. NAME                                                                           | Eugene Hay                            | wkins                                |                                   |                                                                                                                                 |                                  |  |
| 13. NAME  14. BIRTHPLACE (ci                                                       | ity or town) Unki                     | nown                                 |                                   | Name of operation                                                                                                               |                                  |  |
| 15. MAIDEN NAME                                                                    | Unknown                               |                                      |                                   | 23. If death wes due to external causes (VIOL ENCE) fill in else                                                                |                                  |  |
| 15. MAIDEN NAME UNKNOWN  16. BIRTHPLACE (city or town) Unknown  (Stete or country) |                                       |                                      |                                   | Accident, suicide, or homicide? Date of injury, 19                                                                              |                                  |  |
| 17. THE ORIBOTE                                                                    | ospital Rec<br>Crownsville            |                                      | land                              | (Specify city or town, c<br>Specify whether injury occurred in INDUSTRY, in HDME, or                                            | ounty and State) n PUBLIC PLACE. |  |
| 18. BURIAL, CREMATION                                                              |                                       | Thate of                             | 35,19                             | Manner of injury                                                                                                                |                                  |  |
| 19. UNDERTAKER (Address)                                                           | K-P-Whale                             | usty !                               | and the                           | 24. Was disease or injury in eny wey releted to occupation of                                                                   | deceesed?                        |  |
| 20. FILED 6/ 2-3                                                                   |                                       | 7.8                                  | Z Registrar.                      | (Signed CI'OWNS ville M                                                                                                         | M.D.                             |  |
|                                                                                    | If more l                             | lanks are needed,                    | address State Registrar           | , 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.                                                                    | 71000                            |  |

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| -                                                                              |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

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|                                                                                |               |                                                                                |               |

| A. te                                       | STATE OF MARYLAND—                                                                | CERTIFICATE OF DEATH 0627                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8          |
|---------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| state<br>UPA.                               | 1. PLACE OF DEATH                                                                 | (124)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |            |
| ould<br>OCC                                 | County anne armelel                                                               | Registration Dist. No. 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |            |
| -6                                          | Village or City Dewofelyn Park                                                    | ND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Ward       |
| 0                                           | Length of residence in city or town where death occurred                          | death occurred in a hospital or institution, give its NAME instead of street and number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | r)         |
| PHYSICIANS<br>act statement                 | 2. FULL NAME MAD anna Hobba                                                       | 100 mm 10 |            |
| ICI                                         | 3.1                                                                               | St. Ward.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |            |
| IYS                                         | (a) Residence: ND. (Usual place of abode)                                         | If nonresident give city or town and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |            |
| PE                                          | PERSONAL AND STATISTICAL PARTICULARS                                              | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |            |
| Y. Ex                                       | 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) | 21. DATE OF DEATH Jame 7 193                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5          |
| T I                                         | 5a. If married, widowed or divorced                                               | (Month) (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Year)      |
| X A C T                                     | HUSBAND of<br>(or) WIFE of                                                        | 22.   HEREBY CERTIFY. That I attended decease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | sed from   |
|                                             | 0 1 11 1056                                                                       | June 5, 1950, to June 7, 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 9 4        |
| rly rate.                                   | 6. DATE OF BIRTH (manth, day, and year) 7. AGE Years Months Days If LESS than     | to have occurred on the date stated above, at 10 - A, m,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | th is said |
| stated E<br>properly<br>certificate         | 78 7 23 1 day,hrs.                                                                | The PRINCIPAL CAUSE OF DEATH and related causes of importance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |
|                                             | 8 Trade profession or particular                                                  | Penilite - arteriocoluris ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | e of onset |
| be<br>of                                    | kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc.                           | Chronic Myranditis ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            |
| should<br>it may<br>n back                  | Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.   | Cristonia of the line ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |            |
| a it is                                     | D ID. Date deceased last worked at 11. Total time (years)                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
|                                             | this occupation (month and spent in this occupation occupation                    | Dita Cardia a Cardia  |            |
| pplied. AGI<br>erms, so tha<br>instructions | 12. BIRTHPLACE (city or town)                                                     | Dther Contributory Causes of importance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 11         |
| ns, structru                                | (State or country)                                                                | Intestinal Lacomorphage 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5/3        |
| supplied<br>n terms,<br>ee instru           | 13. NAME John Stoppa                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
| st<br>in<br>See                             | 14. BIRTHPLACE (city or town)                                                     | Name of operation Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |            |
| 13                                          | State of country                                                                  | What test confirmed diagnosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 12 120     |
|                                             | I                                                                                 | 23. If death was due to external causes (VIOL ENCE) fill In also the following:  Accident, suicide, or homicide?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10         |
| TTH<br>Dor                                  | (State or equality)                                                               | Where did injury occur?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 19         |
| ld be car<br>DEATH<br>y import              | 17. INFORMANT Prances South                                                       | (Specify city or town, county and State) Specify whether Injury occurred in INDUSTRY, in HDME, or In PUBLIC PLACE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |            |
| should OF D                                 | (Address) 243 Canad                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
| sh<br>E O<br>is v                           | 18. BURIAL, CREMATION, DR'REMOVAL                                                 | Manner of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                             | Place Date June 10, 1933                                                          | Nature of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
| CAUS TION                                   | 19, UNDERTAKER MONTH M. G. TUNGEL                                                 | 24. Was disease or injury in my way related to occupation of deceased?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |            |
| (1)                                         | 20. FILED June 7., 1935 da M. Whilesing. Registrar.                               | (Signed) James Mines Services 1009 annual 36                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | - M. D     |
|                                             |                                                                                   | 2411 N. Charles Street, Balimore, Requesting U. S. No. 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4          |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

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9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

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Example I Example II The principal cause of death and related causes The principal cause of death and related causes Date of onset Date of onset of importance were as follows: of importance were as follows: Arteriosclerosis 1915 Attack of epilepsy 1 week ago Chronic interstitial nephritis 1921 Run over by street car 1 week ago Cerebral hemorrhage Julu 5.1927 Peritonitis 3 days ago Other contributory causes of importance: Other contributory causes of importance: Gallstones May 1,1923 Gastroenteritis 1 wear

| ADDITIONAL.              | SPACE    | FOR    | FURTHER         | STATEMENTS  | RY   | PHYSICIA      | N  |
|--------------------------|----------|--------|-----------------|-------------|------|---------------|----|
| TATA TO Y T Y CO TATA TO | DI ZIUII | I. OIL | T. O TO T THEFT | DIALBRIDATO | 10.1 | I II I SIUIA. | 13 |

| STATE OF MARYLAND—                                                                       | CERTIFICATE OF DEATH 06279                                                               |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                        | 142.0)                                                                                   |
| County Q Q                                                                               | Registration Dist. No.                                                                   |
| Village or City anna Ulis                                                                | No. Emercency, Hospital Ward                                                             |
| Langth of rasidence in city or town whare death occurredyrsmos                           | death occurred in a horpital or institution, give its NAME instead of street and number) |
| 2. FULL NAME Marian Jandes                                                               | y de abour                                                                               |
| (a) Residence: No. 1 Lo H (Usual place of abode)                                         | St., Ward.  If nonresident give city or town and State                                   |
| PERSONAL AND STATISTICAL PARTICULARS                                                     | MEDICAL CERTIFICATE OF DEATH                                                             |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIO OWED, OR DIVORCED (write the word)       | 21. DATE OF DEATH June 1/ 193 V                                                          |
| 5a. It married, widowed, or divorced HUSBANO of                                          | (Month) (Day) (Year)                                                                     |
| (or) WIFE of Welter Jucks                                                                | 22. I HEREBY CERTIFY, That I attended deceased from                                      |
| 6. DATE OF BIRTH (month, day, and year)                                                  | Dolast saw hall alive on fler 1921; death is said                                        |
| 7. AGE Yaars Months Oays If LESS than                                                    | to/have occurred on the date stated above, at 3.20 m.                                    |
| 1 day,hrs.                                                                               | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:           |
| 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER ROOKKEFER etc. | Oate of onset                                                                            |
| 9. Industry or business in which                                                         | allo fre wellbure June!                                                                  |
| work was dona, as SILK MILL, SAW MILL, BANK, etc                                         | ( request these contist require fill 1993                                                |
| 10. Date deceased last worked at this occupation (month and yaar)                        |                                                                                          |
|                                                                                          | Other Coatributery Causes of Importance:                                                 |
| (State or country)                                                                       | , milmal Herioniay fine                                                                  |
| 13. NAME Walter Jamalester                                                               |                                                                                          |
| 14. BIRTHPLACE (city or town) On any of the                                              | Name of operation Rt. Salling - or firelly fue 1011                                      |
| (Stata or country)                                                                       | What tast confirmed diagnosis?                                                           |
| 15. MAIDEN NAME Law Human                                                                | 23. If death was dua to external causes (VIOL ENCE) fill in also the following:          |
| 16. BIRTHPLACE (city or town) (State or country)                                         | Accident, suicide, or homicide?                                                          |
| Che all a la                                               | Whare did Injury occur? (Specify city or town, county and State)                         |
| 17. INFORMANT CAME (Addrass) 10 + 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                      | Specify whether injury occurred in (NDUSTRY, In HOME, of in PUBLIC PLACE.                |
| 18. BURIAL, CREMATION, OR REMOVAL                                                        | Mannar of Injury                                                                         |
| Place Quality Oata 19                                                                    | Nature of Injury                                                                         |
| 19. UNDERTAKER LO KOSE LOS                           | 24. Was disease or injury in any way related to occupation of daceased?                  |
| 20 FUED 2 1.4 10 35- 10 MILAS ASA                                                        | (Signad) Letter with the second M. O.                                                    |
| Registrar.                                                                               | (Addrass) Ullutples, U.A.                                                                |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

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| Example 1                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| **                                                                             |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               | >                                                                              |               |
|                                                                                |               |                                                                                |               |

| ADDITIONAL | SPACE | FOR | FURTHER | <b>STATEMENTS</b> | BY | PHYSICIAN |
|------------|-------|-----|---------|-------------------|----|-----------|
|------------|-------|-----|---------|-------------------|----|-----------|

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V. S. No. 1

BINDING

RESERVED

MARGIN

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| Example I                                                                                        | j             | Example II                                                                                         |                           |
|--------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------|---------------------------|
| The principal cause of death and related causes of importance were as follows:  Arteriosclerosis | Date of onset | The principal cause of death and related causes of importance were as follows:  Attack of epilepsy | Date of onset  1 week ago |
| Chronic interstitial nephritis                                                                   | 1921          | Run over by street car                                                                             | 1 week ago                |
| Cerebral hemorrhage                                                                              | July 5,1927   | Peritonitis                                                                                        | 3 days ago                |
| Other contributory causes of importance:  Gallstones                                             | May 1,1923    | Other contributory causes of importance:  Gastroenteritis                                          |                           |
|                                                                                                  |               |                                                                                                    | 1 year                    |

| ADDITIONAL S | SPACE | FOR | <b>FURTHER</b> | STATEMENTS | BY | PHYSICIAN |
|--------------|-------|-----|----------------|------------|----|-----------|
|--------------|-------|-----|----------------|------------|----|-----------|

state A PERMANENT RECORD. Every item of infor-OCCUPA-PHYSICIANS should of Exact statement stated EXACTLY. properly classified. certificate. WITH UNFADING INK-THIS AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of -WRITE PLAINLY, WITH UNFADI

FOR BINDING

MARGIN RESERVED

| 1. PLACE OF DEA                                                                                                                              | TH C                                  | I WITH             | LAND                                      | (Saca)                                                                                                                                             | J JL                   |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--|--|
| County Anne                                                                                                                                  | Arundel                               |                    |                                           | Registration Dist. No.                                                                                                                             |                        |  |  |
| Village or City                                                                                                                              |                                       | A                  | te Hospi                                  | to No.  death occurred in a hospital or institution, give its NAME instead of street and num.  13 ds. How long in U.S. if of foreign birth?yrsmos. | Ward<br>ober)          |  |  |
| 2. FULL NAME                                                                                                                                 | Narciss                               | sus John           | nson                                      |                                                                                                                                                    |                        |  |  |
| (a) Residence: No.                                                                                                                           |                                       |                    | ,                                         | St., Ward.  If nonresident give city or town and St.                                                                                               | ate                    |  |  |
| PERSONAL AN                                                                                                                                  | ID STATISTI                           | CAL PARTI          | CULARS                                    | MEDICAL CERTIFICATE OF DEATH                                                                                                                       |                        |  |  |
|                                                                                                                                              | or or race<br>lack                    | OR DIVORCE         | RIED, WIDOWED, D (write the word) . dowed | 21. DATE OF DEATH June 12th (Month) (Day)                                                                                                          | 93_ <b>5</b><br>(Year) |  |  |
| 5a. If married, widowed, or div<br>HUSBAND of<br>(or) WIFE of                                                                                | orced<br>Unknown                      |                    |                                           |                                                                                                                                                    | 1935                   |  |  |
| 6. DATE OF BIRTH (month, da                                                                                                                  | v. and vear)                          | 1878 ?             |                                           |                                                                                                                                                    | deeth Is seld          |  |  |
| 7. AGE Years 57?                                                                                                                             | Months Unkno                          | Days<br>DWn        | If LESS than 1 day,hrs. ormin.            | to have occurred on the date stated above, at 11:20P.M.  The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:            | Date of onset          |  |  |
| 8. Trade, profession, or paid with done SAWYER, BOOKKE                                                                                       |                                       | None               | 2                                         | Cerebral hemorrhage and general arteriosclerosis                                                                                                   |                        |  |  |
| kind of work done SAWYER, BOOKKE  9. Industry or business i work was done, as SAW MILL, BANK,  10. Dist deceased last we this occupation (im | SILK MILL,<br>elcorked at<br>onth and | spe                | ime (years)                               |                                                                                                                                                    |                        |  |  |
| 12. BIRTHPLACE (city or town (State or country)                                                                                              |                                       |                    | na na                                     | Other Contributory Causes of Importance:                                                                                                           |                        |  |  |
| 13. NAME                                                                                                                                     | Isaac W                               | ingold             |                                           |                                                                                                                                                    |                        |  |  |
| 13. NAME 14. BIRTHPLACE (city or (State or country)                                                                                          | town) Sout                            | th Carol           | ins                                       | Name of operation Date of What test confirmed diagnosis? Was there en eulopsy?                                                                     |                        |  |  |
| 15. MAIDEN NAME                                                                                                                              | Fannie                                | (Unknown           | 1)                                        | 23. If death wes due to external causes (VIOLENCE) fill In elso the following:                                                                     |                        |  |  |
| 15. MAIDEN NAME  16. BIRTHPLACE (city or (Slate or country)                                                                                  |                                       | outh Car           | olina                                     | Accident, suicide, or homicide? Date of injury Where did injury occur?                                                                             |                        |  |  |
| 17. INFORMANT Hospital Records (Address) Crownsville, Maryland                                                                               |                                       |                    |                                           | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLAC                                   | E,                     |  |  |
| 18. BURIAL, GREMATION, OR Place                                                                                                              | REMOVAL                               | Dete 6/1           | <b>9</b> /25,19                           | Menner of injury                                                                                                                                   |                        |  |  |
| 19. UNDERTAKER (Address)                                                                                                                     | R.P.W.                                | wherod<br>-ry      | Dub.                                      | 24. Was disease or injury in any way related to occupation of deceased? ————————————————————————————————————                                       | 2                      |  |  |
| 20. FILED. 4/19 30                                                                                                                           | , 19 Σ·                               | Flore              | Registrar.                                | (Slaned) Crownsville, Meryland                                                                                                                     | М. С                   |  |  |
|                                                                                                                                              | If more                               | blanks are needed. | address State Registrar                   | , 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.                                                                                       |                        |  |  |

CTATE OF MADVI AND CEPTIFICATE OF DEATH

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| Example I                                                                      | -             | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5, 1927  | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL | SPACE FO | FURTHER | STATEMENTS | BY | PHYSICIAN |
|------------|----------|---------|------------|----|-----------|
|------------|----------|---------|------------|----|-----------|

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| STATE OF                                                                         | MARYLAND—                                            | CERTIFICATE OF DEATH 0629                                                                                        | 52                     |
|----------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|------------------------|
| 1. PLACE OF DEATH                                                                |                                                      | (2,00 m)                                                                                                         | /                      |
| County Q.a.                                                                      | ##====================================               | Registration Dist. No.                                                                                           |                        |
| Village or City annapol                                                          | is onl                                               | No. State St., St., death occurred in a hopital or institution, give its NAME instead of street and nur          | Ward                   |
| Length of residence in city or town where death of                               |                                                      |                                                                                                                  |                        |
| 2. FULL NAME Thud                                                                | 1. Houls                                             | MALA STATE COMPORATE AND CO                                                                                      |                        |
| (a) Residence: No. 978 Uhion                                                     | and Brown                                            | NSV. 4 . Ward.                                                                                                   | V                      |
|                                                                                  | (Usual place of abode)                               | If nonresident give city or town and St                                                                          | ate                    |
| PERSONAL AND STATISTICAL                                                         | L PARTICULARS                                        | MEDICAL CERTIFICATE OF DEATH                                                                                     |                        |
|                                                                                  | INGLE, MARRIED, WIDOWED, R DIVORCED (write the word) | 21. DATE OF DEATH (Month) (Day)                                                                                  | 193                    |
| . If married, widowed, or divorced HUSBAND of                                    |                                                      | 22. I HEREBY CERTIFY That I attended de                                                                          | enand from             |
| (or) WIFE of                                                                     |                                                      | June 2 1935 to June 4                                                                                            | 19.3.5                 |
| DATE OF BIRTH (month, day, and year)                                             | 10-1925                                              | List saw h. en alive on March (4) 19-35                                                                          | death is said          |
| AGE Years Months                                                                 | Days   If LESS than                                  | to have occurred on the date stated above, at 1-45 Rm.                                                           |                        |
| 10 3                                                                             | 25   1 day, hrs. ormin.                              | The PRINCIPAL CAUSE OF DEATH and related causes of importance                                                    | Date of onset          |
| 8. Trade, profession, or particular                                              |                                                      |                                                                                                                  | -//-                   |
| kind of work done, as SPINNER,<br>SAWYER, BOOKKEEPER, etc                        |                                                      | martined Smill                                                                                                   | 6-4-3                  |
| 9-Industry or business In which work was done, as SILK MILL, SAW MILL, BANK, etc |                                                      |                                                                                                                  |                        |
| 10. Date deceased last worked at                                                 | 11. Total time (years)                               |                                                                                                                  |                        |
| this occupation (month and year)                                                 | spent in this occupation                             |                                                                                                                  |                        |
| BIRTHPLACE (city or town) New 40                                                 | ork dily                                             | Other Contributory Causes of importance:                                                                         |                        |
| (State or country)                                                               |                                                      |                                                                                                                  |                        |
| 13. NAME Tolers TV                                                               | aufman                                               |                                                                                                                  |                        |
| 14. BIRTHPLACE (city or town)                                                    |                                                      | Name of operation Date of                                                                                        |                        |
| (State or country) West of                                                       | off cely                                             | What test confirmed diagnosis? Was there an au                                                                   | opsy?                  |
| 15. MAIDEN NAME Word Set                                                         | igmans                                               | 23. If death was due to external causes (VIOL ENCE) fill in also the following:                                  |                        |
| 15. MAIDEN NAME Roca See  16. BIRTHPLACE (city or town)  (State or country)      | <u>/</u>                                             | Accident, suicide, or homiciden Accident, Spate of injury                                                        | , 19                   |
| (State or country)                                                               | a                                                    | Where did injury occur? Specify city or town, county and State                                                   | 4                      |
| INFORMANT Poleck Kary                                                            | mus                                                  | (Specify city of town, county and State) Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLAC | E.                     |
| (Address) Gry & Union are 1/2                                                    | In your                                              | 11.10000000                                                                                                      |                        |
| 8. BURIAL, CREMATION, OR REMOVAL Place Man Your D                                | ate lance 4 35                                       | de Maria de Maria                                                                                                | 10                     |
| n 4 21 10                                                                        | A                                                    | Nature of Injury Many Many                                                                                       | To                     |
| 9. UNDERTAKER 3 3 4 1 1                                                          | my A                                                 | 24. Wes disease or injury in any way related to occupation of deceased?                                          | V.(A.)                 |
| (Address)                                                                        | Out of                                               | If so, specify AC I AT NO                                                                                        | 0                      |
| 0. FILED 9 4 , 19.35                                                             | Murph:                                               | (Signed) (Address) 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                                                           | Lery D                 |
| ( ) (                                                                            | Registrar.                                           | (undiess)                                                                                                        | agreement and a second |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example 1                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
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| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL | SPACE | FOR | <b>FURTHER</b> | STATEMENTS | BY | PHYSICIAN |
|------------|-------|-----|----------------|------------|----|-----------|
|------------|-------|-----|----------------|------------|----|-----------|

# STATE OF MARYLAND—CERTIFICATE OF DEATH

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|---|---|---|---|----|--|
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|       | 1. PLACE OF DEATH                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                 | (31)                                                                                                                                |
|-------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
|       | County ( Www                                                                            | ie Un                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | un                    | del                             | Registration Dist, Np.                                                                                                              |
|       | Village or City                                                                         | rem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 16                    | elmon                           | //No. St., Ward                                                                                                                     |
|       | Langth of residence in city or tov                                                      | wn whara death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ccurred               | Syrs mos                        | death occurred in n horpital or institution, give its NAME instead of street and number)  ds. How long in U.S. if of foreign birth? |
| 1     | 2. FULL NAME W                                                                          | 1000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 110                   | K. 00                           | 711 -                                                                                                                               |
|       | (a) Residence: ND.                                                                      | 10 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                       |                                 | old and had                                                                                                                         |
|       | (a) hesidence. No.                                                                      | jeri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Usual place of       | of abode)                       | If nonresident give city or town and State                                                                                          |
| _     | PERSONAL AND ST                                                                         | ATISTICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PARTI                 | CULARS                          | MEDICAL CERTIFICATE OF DEATH                                                                                                        |
|       | 3. SEX 4. COLOR OR R                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | RIED, WIDOWED, (write tha word) | 21. DATE OF DEATH 1 5                                                                                                               |
| 1     | jemide Worte                                                                            | el                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | m                     | arneg                           | (Month) (Day) (Year)                                                                                                                |
|       | HUSBAND of (or) WIFE of                                                                 | 1.0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | /                     | 00                              | 22. HEREBY CERTIFY, That I attended deceased from                                                                                   |
| -     | (b) with the                                                                            | asie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2 6                   | elly                            | Tyay 15 ,935, 10 June 12/1935                                                                                                       |
| 1     | 6. DATE OF BIRTH (month, day, and ya                                                    | 181) Unkn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | oun                   | 1875                            | I last saw h. Rea alive on June 12 1935; death is said                                                                              |
| 1     | 7. AGE Years M                                                                          | tonths                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Days                  | If LESS than I day,hrs.         | to have occurred on the data rated above, at                                                                                        |
| -     | 60                                                                                      | 111                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | ormin.                          | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                                      |
| 1     | 8. Trade, profession, or particular kind of work done, as SPIN SAWYER, BOOKKEEPER, etc. | NNER.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | use                   | wilo                            | a Cul Cardia Julius                                                                                                                 |
| 1     | 9 Industry or business in which                                                         | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       |                                 |                                                                                                                                     |
| 11.5  | CAW MILL DAMK oto                                                                       | LL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       |                                 |                                                                                                                                     |
| 18    | 10. Date daceased last worked at this occupation (month and                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | II. Total tip<br>spen | t in this                       |                                                                                                                                     |
| -     | year)                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OC2 II                | pation                          | Other Contributory Causes of importance:                                                                                            |
| 1     | 12. BIRTHPLACE (city or town)                                                           | 1110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | us.                   |                                 | Thy pertenne Caroles Varcular                                                                                                       |
| 0     | 1 /11-                                                                                  | and a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | An                    | 10                              | Keyal Gastan                                                                                                                        |
| 17.   |                                                                                         | THE STATE OF THE S | 2 In                  | ancing                          | Chronte Merchas If phones                                                                                                           |
| · L   | (State or country)                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | y mi                  |                                 | Name of operation Data of What test confirmed diagnosis? Was there an autopsy?                                                      |
| 0     | 15. MAIDEN NAME                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | V                     |                                 | 23-44 death was due to axternal causes (VIOLENCE) fill in also the following:                                                       |
| TON.  | 16. BIRTHPLACE (city or town)                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                 | Accident, suicede or homicida?                                                                                                      |
| 3     | E (State or country)                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ,                     |                                 | Whare did injury occur?                                                                                                             |
| 1     | 17. INFORMANT / Her                                                                     | myl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1/0                   | Sne                             | Specify whether injury occurred in INDUSTRY in HOME, or in PUBLIC PLACE.                                                            |
| -     | (Address) 5                                                                             | 5/19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | yun                   | yo gaft                         |                                                                                                                                     |
|       | 18. BURIAL, CREMATION, OR REMOVAL                                                       | ach Da                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Yun                   | e 16 1936                       | Manner of injury                                                                                                                    |
| -     | Anss                                                                                    | 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | JA .                  |                                 | Nature of injury                                                                                                                    |
| 1     | 19. UNDERTAKER 12/7                                                                     | 199                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10                    | 12                              | 24. Was disease or injury In any way related to occupation of daceased?                                                             |
| -     | Quality 20                                                                              | 16 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1)                    | 74                              | (Signad) M.D. M.D.                                                                                                                  |
| 1     | 20. FILED JUNE 14, 1935                                                                 | 11-0-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | XOV                   | Registrar.                      | (Signal) (Address) (Address)                                                                                                        |
| ditte |                                                                                         | If more blanks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | are needed, ac        |                                 | 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.                                                                          |

S. No. 1

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| Chronicrinterstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| - Sp. Q.                                                                       |               |                                                                                |               |
| Other contributory causes of importance.                                       | 2             | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1928      | Gastroenteritis                                                                | 1 year        |
| \ in                                                                           | 7             |                                                                                | 2 2 2 1       |
| 100                                                                            |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

V. S. No. 1

| STATE OF | MARYLAND—CERTIFICATE OF DEATH | 062 |
|----------|-------------------------------|-----|
|----------|-------------------------------|-----|

| 1. PLACE                                                                                                                                                                                                                                                                                                                                    | L PLACE OF DEATH                                                                                                     |            |                                   | 210-m                                                                                                                                                                                                   |                     |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--|--|
| County                                                                                                                                                                                                                                                                                                                                      | Anne Arun                                                                                                            | ndel       |                                   | Registration Dist. No. 27                                                                                                                                                                               |                     |  |  |
|                                                                                                                                                                                                                                                                                                                                             | Village or City Ft. George G. Meade, Md.  (II  Length of residence in city or town where death occurred 2 yrs. 5 mos |            |                                   | No. Station Hospital St., —  death occurred in a hospital or institution, give its NAME instead of street and number 20 ds. How long in U. S. if of foreign birth? ———————————————————————————————————— | Ward                |  |  |
| 2 FILL N                                                                                                                                                                                                                                                                                                                                    | AME George                                                                                                           | Kotchmor   |                                   |                                                                                                                                                                                                         |                     |  |  |
|                                                                                                                                                                                                                                                                                                                                             | ence: No. Ft. Geor                                                                                                   |            | de, Md.                           | St., Ward.  If nonresident give city or town and State                                                                                                                                                  |                     |  |  |
| PERSO                                                                                                                                                                                                                                                                                                                                       | NAL AND STATIST                                                                                                      | ICAL PARTI | CULARS                            | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                            |                     |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                              | 4. COLOR OR RACE White                                                                                               |            | RIED, WIDOWED, O (write tha word) | 21. DATE OF DEATH June  (Month) (Day)                                                                                                                                                                   | 5<br>(Year)         |  |  |
| 5a. If married, widowed, or divorcad HUSBAND of (or) WIFE of                                                                                                                                                                                                                                                                                |                                                                                                                      |            |                                   | 22. I HEREBY CERTIFY, Thet I ettended deceased fr  June 4, 19.35, to June 4, 19.35                                                                                                                      |                     |  |  |
| 6. DATE OF BIRT                                                                                                                                                                                                                                                                                                                             | H (month, dey, end yeer)                                                                                             | Nov. 18.   | 1911                              | Hest sew him alive on June 4, 1935; dec                                                                                                                                                                 | eth is sald         |  |  |
|                                                                                                                                                                                                                                                                                                                                             | Years Months                                                                                                         | Deys       | if LESS than I dey,hrs. ormin.    | to have occurred on the date stated ebove, et_2:208_m.  The PRINCIPAL CAUSE OF DEATH and related causes of importence were as follows:                                                                  | te of onset         |  |  |
| B Trada, profession, or particular kind of work done, es SPINNER, Soldier SAWYER, BOOKKEEPER, etc.  Industry or business in which work wes done, as SILK MILL, 34 th Inf. U.S. Army SAW MILL, BANK, etc.  10. Data deceased last worked at this occupation (month and yeer)  11. Totel time (years) spent in this occupation 2 occupation 2 |                                                                                                                      |            |                                   | Contusion, severe, upper cervical region, spinal cord, caused by fracture, bodies of 2nd & 3rd Vertebrae.                                                                                               | une 4               |  |  |
| 12. BIRTIIPLACE (State or co                                                                                                                                                                                                                                                                                                                | (city or town) Milne                                                                                                 | esville    | petion                            | Other Coutributory Causes of Importance:                                                                                                                                                                | ~~~~~               |  |  |
|                                                                                                                                                                                                                                                                                                                                             | (unknown) Kot                                                                                                        | tchmore    |                                   | Automobile accident.                                                                                                                                                                                    |                     |  |  |
| 14. BIRTHPLA                                                                                                                                                                                                                                                                                                                                | CE (city or town) Unkr                                                                                               |            |                                   | Nama of operation                                                                                                                                                                                       |                     |  |  |
|                                                                                                                                                                                                                                                                                                                                             | 77-1                                                                                                                 |            |                                   | Whet test confirmed diagnosis? X=RAY Was thara en eulop:                                                                                                                                                | sy? JSLY            |  |  |
| 15. MAIDEN NAME UNKNOWN  16. BIRTHPLACE (city or town)  (State or country)                                                                                                                                                                                                                                                                  |                                                                                                                      |            |                                   | 23. If death was due to external causes (VIOLENCE) fill in also the following:  Accident, suicide, or homicide? Accident Dete of injury Tune 4,493  Where did injury occurate Geo. G. Meade, Md.        |                     |  |  |
| 17. INFORMANT (Address)                                                                                                                                                                                                                                                                                                                     |                                                                                                                      |            |                                   | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.  U. S. Army Reservation.                                                                                                      |                     |  |  |
| Plece Ha                                                                                                                                                                                                                                                                                                                                    | ation, or REMOVAL<br>zleton, Pa.                                                                                     |            |                                   | Menner of injury Automobile accident.  Neture of injury Broken neck                                                                                                                                     |                     |  |  |
| 19. UNDERTAKER<br>(Address)                                                                                                                                                                                                                                                                                                                 | R. Brooks & S                                                                                                        | on, Baltin | nore, Md.                         | 24. Wes disease or injury in any way related to occupetion of deceased? No.                                                                                                                             |                     |  |  |
| PO. FILED JULY                                                                                                                                                                                                                                                                                                                              | 5, 1935                                                                                                              | C.E.Fre    | eman, Col                         | (Signed) B. Norris, Maj.M<br>(Address) Fort George G. Meade, M                                                                                                                                          | .С <sub>м. д.</sub> |  |  |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| e of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                            |
|------------|--------------------------------------------------------------------------------|------------------------------------------|
| 1015       |                                                                                |                                          |
| 1915       | Attack of epilepsy                                                             | 1 week ago                               |
| 1921       | Run over by street car                                                         | 1 week ago                               |
| y5,1927    | Peritonitis                                                                    | 3 days ago                               |
|            | Other contributory causes of importance:                                       |                                          |
| y 1,1923   | Gastroenteritis                                                                | 1 year                                   |
| 3          | y5,1927                                                                        | Other contributory causes of importance: |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

BINDING

RESERVED

MARGIN

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5, 1927  | Peritonitis ·                                                                  | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       | -             |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Balinmore, Requesting V. S. Ao. 1.

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|-----------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------|---------------|
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| Cerebral hemorrhage                                                         | July 1927         | Peritonitis                                                                    | 3 days ago    |
| y                                                                           | 1                 |                                                                                |               |
| Other contributory causes of importance:                                    | Dan.              | Other contributory causes of importance:                                       |               |
| Gallstones                                                                  | Way 1,7923        | Castroenteritis                                                                | 1 year        |
|                                                                             |                   |                                                                                |               |
|                                                                             | N                 |                                                                                |               |





## STATE OF MARYLAND—CERTIFICATE OF DEATH

06287

| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (83,20)                                                                                                            |        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------|
| County Anne Arundel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Registration Dist. No. Ld                                                                                          |        |
| Village or City Jessup, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | No.Maryland House of Correction W                                                                                  | ard    |
| The Cartesian Clarence Clarenc | death occurred in a hospital or institution, give its NAME instead of street and number)                           |        |
| Length of residence in city or town where death occurredyrs,8mos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                    | _ds.   |
| 2. FULL NAME John T. Mason                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Not knownif veteran                                                                                                |        |
| (a) Residence: No. (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | t St., Ward. Baltimore 1 mad State                                                                                 | 5      |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                       |        |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OB DIVORCED Curite the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. DATE OF DEATH  June-28-1935                                                                                    |        |
| 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Month) (Day) (Year)                                                                                               | ,      |
| HUSBAND of MAD A Relation Management                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 22. I HEREBY CERTIFY, That I attended deceased f                                                                   | from   |
| may prane mason                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | June-28-35 , 19 , 10 June-28-35 , 19                                                                               |        |
| 6. DATE OF BIRTH (month, day, and year) Capril 14, 186                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I last saw h im alive on June-28-1935 , 19 ; death is                                                              | seld   |
| 7. AGE Years Months Oays If LESS than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | to have occurred on the date stated above, at5:15m.P.M.                                                            |        |
| 73 2 14 I day,hrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                     | -      |
| 8. Trade, profession, or particuler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Cerebral Hemorrhage 6-28                                                                                           |        |
| kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Arteriosclerosis ?                                                                                                 |        |
| 9. Industry or business in which work was done, as SILK MILL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                    |        |
| SAW MILL, BANK, etc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                    |        |
| 11. Total time (years) this occupetion (month and spent in this                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                    |        |
| year) occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Other Contributory Causes of Importance:                                                                           |        |
| 12. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                    |        |
| (State er country) (State er country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                    |        |
| 13. NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                    |        |
| 13. NAME  14. BIRTHPLACE (city or town).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Name of operation                                                                                                  |        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What test confirmed diagnosis? NONE Was there an autopsy?                                                          | no     |
| E 15. MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23. If death was due to external ceuses (VIOLENCE) fill in also the following:                                     |        |
| E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Accident, suicide, or homicide? Oate of injury19                                                                   |        |
| 16. BIRTHPLACE (city or town)  (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Where did injury occur?                                                                                            |        |
| July Garage Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. |        |
| (Address) 4435 Old 17mb D. A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | open, maner many country in most in interest in interest.                                                          |        |
| 18. BURIAL, CREMATION, OR REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Manner of injury                                                                                                   | ~- ~ - |
| Place 24 + 1) / 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Neture of injury                                                                                                   |        |
| The state of the s |                                                                                                                    |        |
| 19. UNOERTAKER Se IlMan Lemmon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24. Was disease or injury in any way related to occupation of decease NO                                           |        |
| (Address) 4611 Pase Idel Olfs. Balton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | If so, specify                                                                                                     |        |
| 20. FILED 1929 , 1985 - Olara M. Hasluft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (Signed) / Mary Many and                                                                                           | M. D.  |
| Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (Address) Jessup, Maryland                                                                                         |        |

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| Example I                                                                      | li            | Example II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Date of onset |
| Arterioselerosis                                                               | 1915          | Attack of epilepsy • •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 year        |
|                                                                                |               | THE STATE OF THE S |               |

STATE OF MARYLAND-CERTIFICATE OF DEATH

(Signed)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Ballmore, Requesting V. S. No. 1.

Registrar.

(Yeer)

Date of onset

10

(Day)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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9.—The industry or business in which the work was done.

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| Example I                                                                                                   | -             | Example II                                                                     |               |
|-------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| Example I  The principal cause of death and related causes of importance were as follows:  Arteriosclerosis | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                                                            | 1 15          | Attack of epilepsy                                                             | 1 week ogo    |
| Chronic interstitiol nephritis                                                                              | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage 12 1935                                                                                 | July 5,1927   | Peritonitis                                                                    | 3 doys ogo    |
| Other contributory causes of importance:                                                                    |               | Other contributory causes of importance:                                       |               |
| Gollstones .                                                                                                | May 1,1923    | Gostroenteritis                                                                | 1 year        |
|                                                                                                             |               |                                                                                |               |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting O. S. No. 1.

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL S | SPACE FOR | FURTHER | STATEMENTS | BY | PHYSICIAN |
|--------------|-----------|---------|------------|----|-----------|
|--------------|-----------|---------|------------|----|-----------|

V. S. No. 1

| STATE OF MARYLAND—                                                                                                                                                                                  | CERTIFICATE OF DEATH                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                   | (3)                                                                                                                |
| County 4                                                                                                                                                                                            | Registration Dist. No.                                                                                             |
| Village or City acuse and el                                                                                                                                                                        | death occurred in a hospital or institution, give at NAME instead of street and number)                            |
| Length of residence in city of own where death occurred 3 yrs mos.                                                                                                                                  |                                                                                                                    |
| 2. FULL NAME TRumal Men.                                                                                                                                                                            | share sol                                                                                                          |
| (a) Residence: No. Arms Arms/70                                                                                                                                                                     | St. YOWAR MI                                                                                                       |
| (Usual place of abode)                                                                                                                                                                              | If nonresident give city or town and State                                                                         |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                | MEDICAL CERTIFICATE OF DEATH                                                                                       |
| 3. SEX 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (corric the word)                                                                                                           | 21. DATE OF DEATH  (Month) (Dey) (Year)                                                                            |
| 5e. If married, widowed, or divorced<br>HUSBAND of                                                                                                                                                  | 1 HEREBY CERTIFY Tast I attended deceased from                                                                     |
| (or) WIFE of                                                                                                                                                                                        | her by he 34 to to the 27 19 35                                                                                    |
| 6. DATE OF BIRTH (month, day, and year) OFT 4-1855                                                                                                                                                  | last sawh alive on 2 /67, 19 3/5; death is said                                                                    |
| 7. AGE Years Months Days If LESS than                                                                                                                                                               | to heve occurred on the date stated above, atm.                                                                    |
| 79 8 23   I day,hrs.   ormin.                                                                                                                                                                       | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                     |
| Trade, profession, or particular kind of work done, as SPINNER Laboree                                                                                                                              | Character 4 1 193                                                                                                  |
| kind of work done, as SPINNER SAWYER, BOOKKEEPER, etc. Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc.  10. Date deceesed lest worked at this occupation (month and | 1000000                                                                                                            |
| Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc.                                                                                                                     | Obstrites -                                                                                                        |
| 10. Date deceesed lest worked at spent in this occupation (month and year) occupetion occupetion                                                                                                    |                                                                                                                    |
| 12, BIRTHPLACE (city or town) ac Co                                                                                                                                                                 | Other Contributory Causes of importence:                                                                           |
| (State of country)                                                                                                                                                                                  | United Deliposa.                                                                                                   |
| 13. NAME au Beren Menshaw                                                                                                                                                                           | Devend Hears durations                                                                                             |
| 13. NAME OU Deven Menshaw  14. BIRTHPLACE (city or town) a a country  (State or country)                                                                                                            | Neme of operation Dete of                                                                                          |
| (Stete or country)                                                                                                                                                                                  | What test confirmed diegnosis? Was there en autopsy?                                                               |
| 15. MAIDEN NAM LESQUE Waters                                                                                                                                                                        | 23. If death was due to external causes (VIOL ENCE) fill in elso the following:                                    |
| 15. MAIDEN NAM LUSAU Wales  16. BIRTHPLACE (city or town)  (Statemer country)                                                                                                                       | Accident, suicide, or homicide? Date of injury, 19                                                                 |
| ∑ (Stateppr country)                                                                                                                                                                                | Where did injury occur?                                                                                            |
| 17. Informant Ama Walls (Address) Down The Sand                                                                                                                                                     | (Specify city or town, county and State) Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. |
| 18. BURIAL, OREMATION OR REMOVAL                                                                                                                                                                    | Manner of Injury                                                                                                   |
| Plece Odereln In of Dete 7 7 133                                                                                                                                                                    | Nature of injury.                                                                                                  |
| 19. UNDERTAKED. This Wicliams And                                                                                                                                                                   | 24. Wes disease or injury in any way related to occupation of deceased?                                            |
| (Address) Waleshing Ind                                                                                                                                                                             | If so, specify ABOVISON TOURS                                                                                      |
| 20. FILED / 29 , 1950 & F. Registrar.                                                                                                                                                               | (Signed) (Address)  (Address)  (Address)                                                                           |
| If more blanks are needed, address State Registrar,                                                                                                                                                 | 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.                                                         |

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
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| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5, 1927  | Peritonitis                                                                    | 3 days ago    |
|                                                                                |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

STATE OF MARYLAND—CERTIFICATE OF DEATH 1. PLACE OF DEATH CCC Registration Dist. No. Village or City (If death occurred in a hospital or institution, give its NAME instead of street and number) Length of residence in city or town where death occurred How long in U.S. if of foreign birth? \_\_\_\_\_\_yrs. \_\_\_\_\_mos. \_\_\_\_ds. (a) Residence: No. If nonresident give city or town and State PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 5. SINGLE, MARRIED, WIDOWED, 21. DATE OF DEATH OR DIVORCED (write the word) 5a. If married, widowed, or divorced HUSBAND of HEREBY CERTIFY) That i attended deceased from (or) WIFE of 6. DATE OF BIRTH (month, day, and year 7. AGE Days If LESS than to have occurred on the detectated above, at 1 day, ....hrs or\_\_\_\_min. 8. Trade, profession, or particuler NO kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc ... may 9. Industry or business in which plnous work was done, as SILK MILL, SAW MILL, BANK, etc..... 10 Date deceesed last worked at 11. Total time (years) this occupation (month and spent in this occupation (State or country) FATHER 13. NAME See 14. BIRTHPLACE (city or town Name of operation..... (State or country) Whet test confirmed diagnosis?\_\_\_\_\_ Wes there an autopsy?\_\_\_\_ d MOTHER 15. MAIDEN NAME 23. If death was due to external causes (VIOL ENCE) fill in also the following: 16. BIRTHPLACE (city or town Accident, suicide or homicide?\_\_\_ Date of injury (State or country Where did injury occur? (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in NUME, or In PUBLIC PLACE. should 17. INFORMANT (Address) 18. BURIAL, CREMATION, OR REMOV. Manner of intuity mation TION Nature of Injury. 24. Was diseese or injury in any way related to occupation of deceased? (Address) If so, specify (Signed) If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

BINDI

RESERVED

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| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| WIREAU V. S.                                                                   |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                | 1             |                                                                                |               |

| ADDITIONAL SPACE FOR FURTHER STAT | FEMENTS BY PHYSICIAN | 1 |
|-----------------------------------|----------------------|---|
|-----------------------------------|----------------------|---|

BINDIN

FOR

MARGIN RESERVED

S. No.

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| Example I                                                                      | -             | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
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| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| <u>6</u> |  |
|----------|--|
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|          |  |
|          |  |
|          |  |

AD. Every item of inforshould state Exact statement of OCCUPA-PHYSICIANS stated EXACTLY. WITH UNFADING INK-THIS IS A PERMANENT properly classified. MARGIN RESERVED FOR BINDING TION is very important. See instructions on back of certificate. AGE should be CAUSE OF DEATH in plain terms, so that it may be mation should be carefully supplied. B.—WRITE PLA

V. S. No. 1

| STATE OF MARYLAND—                                                                                 | CERTIFICATE OF DEATH 06293                                                                             |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                  | (46-B)                                                                                                 |
| County auge arundel                                                                                | Registration Dist. No.                                                                                 |
| Village or City Scale of audung                                                                    | No. St., Ward death occurred in a hospital or institution, give its NAME instead of street and number) |
| Langth of rasidance in city or town where death occurredyrs,mos.                                   | ds. How long in U.S. if of foreign birth?yrsmosds.                                                     |
| 2. FULL NAME Conge C. Cas                                                                          | has                                                                                                    |
| (a) Residence: No. (Usual place of abode)                                                          | St., Ward.  If nonresident give city or town and State                                                 |
| PERSONAL AND STATISTICAL PARTICULARS                                                               | MEDICAL CERTIFICATE OF DEATH                                                                           |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)                  | 21. DATE OF DEATH                                                                                      |
| 5a. If married, widowed, or divorcad                                                               | (Month) (Day) (Year)                                                                                   |
| HUSBAND of (or) WIFE of Managers of Parties                                                        | 22. I HEREBY CERTIFY, That I attended dacased from                                                     |
| mailsidal                                                                                          | Mast saw here alive on Illust 10 11, 19.35; dath is said                                               |
| 6. DATE OF BIRTH (month, day, and year) 7. AGE Years Months Days If LESS than                      | to have occurred on the date stated above, at                                                          |
| 65 71 29 Iday,hrs.                                                                                 | The PRINCIPAL CAUSE OF DEATH and ralated causes of importance were as follows:                         |
| Trada, profassion, or particular kind of work done, as SPINNER, According to SAWYER BODKKEEPER atc | Carlesto thead States for                                                                              |
| SAWYER, BDDKKEEPER, atc.                                                                           |                                                                                                        |
| work was done, as SILK MILL,                                                                       |                                                                                                        |
| U 10. Data decaased last worked at 11. Total tima (yaars)                                          |                                                                                                        |
| this occupation (month and year) spent in this occupation 3.0                                      |                                                                                                        |
| 12. BIRTHPLACE (city or town)                                                                      | Othar Contributory Causes of importance:                                                               |
| (State or country)                                                                                 |                                                                                                        |
| 13. NAME Glas J. C. Parfus S./ 14. BIRTHPLACE (city or town) Mary faced.                           |                                                                                                        |
| 14. BIRTHPLACE (city or town) Mary for                                                             | Name of oparation                                                                                      |
| (State of country)                                                                                 | What tast confirmed diagnosis? Was there an autopsy?                                                   |
| 15. MAIDEN NAME WALLOWN                                                                            | 23. If daath was due to axtarnal causes (VIDLENCE) fill In also the following:                         |
| 16. BIRTHPLACE (city or town)                                                                      | Accident, suicide, or homicide?                                                                        |
| (State or country)                                                                                 | Where did injury occur? (Specify city or town, county and State)                                       |
| 17. INFORMANT Sauget of Landing and                                                                | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                              |
| 18. BURIAL, CREMATION, UK REMOVAL 7 78 3 -                                                         | Mannar of injury                                                                                       |
| Place James Date June 13, 1930                                                                     | Natura of injury                                                                                       |
| 19. UNDERTAKER Pobert Wood;                                                                        | 24. Was disease or injury in any way ralated to occupation of decaasad?                                |
| (Addrass) Freedalys. Mig                                                                           | If so, spacify                                                                                         |
| 20. FILED dune 1935 W.M. Claylor                                                                   | (Signed) M. D.                                                                                         |
| Registrar.                                                                                         | (Address)                                                                                              |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, ctc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I                                                                      |               | Example II                                                                     | -0.7          |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| E E E E E E E E E E E E E E E E E E E                                          |               | <u> </u>                                                                       |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

20. FI

STATE OF MARYLAND-CERTIFICATE OF DEATH 1. 2. 3. SE 5a. If 6. DA 7. AG OCCUPATION 12. B FATHER MOTHER 17. tf 18. B 19. U

06294

| PLACE OF DEATH                                                                               | (B)                                                                                                                                            |
|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| County A.A. (or Home                                                                         | Registration Dist. No. 20                                                                                                                      |
| Village or City 2 d Cewares                                                                  | ND. St., Ward                                                                                                                                  |
| //                                                                                           | I death occurred in a hospital or institution, give its NAME instead of street and number)  ds. How long in U.S. if of foreign birth?yrsmosds. |
| P-11                                                                                         |                                                                                                                                                |
| FULL NAME Jakes Jakes                                                                        | an.                                                                                                                                            |
| (a) Residence: No. (Usual place of abode)                                                    | St., Ward.  Il nonresident give city or town and State                                                                                         |
| PERSONAL AND STATISTICAL PARTICULARS                                                         | MEDICAL CERTIFICATE OF DEATH                                                                                                                   |
| 4. COLOR OR RACE   S. SINGLE, MARRIED, WIDOWED,                                              | 21. DATE OF DEATH                                                                                                                              |
| OR DEVORCED (write the word)                                                                 | (Month) (Day) (Year)                                                                                                                           |
| married, widowed, or divorced                                                                |                                                                                                                                                |
| OF WIFE OF TO TOWN TOWN TOWN TOWN TOWN TOWN TOWN T                                           | 22. I HERTEBY CERTIFY, That I attended deceased from                                                                                           |
| 1856211                                                                                      | Thest saw how alive on June 17 1935 : death is said                                                                                            |
| TE OF BIRTH (month, day, and year)  E Years Months Days If LESS than                         | to have occurred on the date stated above, atm.                                                                                                |
| 7/1 1 day,hrs.                                                                               | The PRINCIPAL CAUSE OF DEATH and related causes of importance                                                                                  |
| 8 Trade profession or particular                                                             | were as follows:                                                                                                                               |
| 8. Trade, profession, or particular kind of work done, as SPINNER, - SAWYER, BODKKEEPER, etc | mouse in less that that                                                                                                                        |
| 9. Industry or business in which                                                             | 0 10                                                                                                                                           |
| work was done, as StLK MILL,<br>SAW MILL, BANK, etc.                                         | Meshritis                                                                                                                                      |
| Date deceased last worked at this occupation (month and spent in this                        |                                                                                                                                                |
| year)occupation                                                                              | Other Contributory Causes of importance:                                                                                                       |
| RTHPLACE (city or town)                                                                      |                                                                                                                                                |
| (State or country) Mills, Flats has when                                                     |                                                                                                                                                |
| 3. NAME                                                                                      |                                                                                                                                                |
| 4. BIRTHPLACE (city or town)                                                                 | Name of operation Date of                                                                                                                      |
| (State or country) //                                                                        | What test confirmed diagnosis? What dest was there an autopsy                                                                                  |
| 5. MAIDEN NAME                                                                               | 23. If death was due to externat causes (VIDLENCE) fill in also the following:                                                                 |
| 6. BIRTHPLACE (city or town)                                                                 | Accident, suicide, or homicide? Date of injury, 19                                                                                             |
| (State or country)                                                                           | Where did injury occur? (Specily city or town, county and State)                                                                               |
| FORMANT MB, WM Jucker                                                                        | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                                                                      |
| (Address) a a Co. Home Tho.                                                                  |                                                                                                                                                |
| DRIAL, CREMATION, ORTREMOVAL                                                                 | Manner of injury                                                                                                                               |
| Place Date Line 1900                                                                         | Nature of injury                                                                                                                               |
| NDERTAKER LAS. D. CON - h                                                                    | 24. Was disease or injury in any way related to occupation of deceased?                                                                        |
| (Address) Davidon-100 m                                                                      | If so, specify Among Hange                                                                                                                     |
| LED June 185 Carrie & Switt                                                                  | (Signed) M.D.                                                                                                                                  |
| // Registrar.                                                                                | (Address)                                                                                                                                      |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| 1             | Example II                                                                     |                                                                                                                                                          |
|---------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                                                                                                                            |
| 1915          | Attack of epilepsy                                                             | 1 week ago                                                                                                                                               |
| 1921          | Run over by street car                                                         | 1 week ago                                                                                                                                               |
| July 5, 1927  | Peritonitis                                                                    | 3 days ago                                                                                                                                               |
|               | AECEIVED                                                                       |                                                                                                                                                          |
| May 1,1923    | Other contributory causes of importance:                                       | 1 year                                                                                                                                                   |
|               |                                                                                |                                                                                                                                                          |
|               | 1915<br>1921<br>July 5,1927                                                    | of importance were as follows:  1915 Attack of epilepsy  1921 Run over by street car  July 5, 1927 Peritonitis  Other contributory causes of importance: |

ż

| 1. PLACE                                                                                                                                                                                                                                            | OF DEATH                                                                                                           |                                        |                                      | 46-6                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| County                                                                                                                                                                                                                                              | Anne Arun                                                                                                          | del                                    |                                      | Registration Dist. No. 21                                                                                                                                                            |
| Village or<br>Length of re                                                                                                                                                                                                                          | City Annapo                                                                                                        |                                        | 6 yrs 8 mos                          | No. Emergency Hospital St., 2 Ward death occurred in a hospital or institution, give its NAME instead of street and number)  ds. How long in U.S. if of foreign birth? yrs. mos. ds. |
| 2. FULL NA                                                                                                                                                                                                                                          | AME WILLIA<br>ence: No. 308 Wes                                                                                    |                                        | ND PUCKE                             | PT St., 3 Ward.                                                                                                                                                                      |
|                                                                                                                                                                                                                                                     |                                                                                                                    | (Usual place                           |                                      | If nonresident give city of fown and State                                                                                                                                           |
|                                                                                                                                                                                                                                                     | NAL AND STATIST                                                                                                    |                                        |                                      | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                         |
| male male                                                                                                                                                                                                                                           | 4. COLOR OR RACE white                                                                                             | or Divorced (write the word) e married |                                      | 21. DATE OF DEATH  (Month)  (Day)  (Year)                                                                                                                                            |
| 5a. If merried, widowed, or divorced HUSBAND of Theresa Mary Puckett (or) WIFE of                                                                                                                                                                   |                                                                                                                    |                                        | ckett                                | 22. I HEREBY CERTIFY. That I attended deceased from  Nay 14 1935 to Surve 7 1935                                                                                                     |
| 6. DATE OF BIRTH                                                                                                                                                                                                                                    | (month, day, end year) Se                                                                                          | nt. 24.                                | 1888                                 | I last saw h Langelive on Jame 4 19.35 death is said                                                                                                                                 |
| 7. AGE Y                                                                                                                                                                                                                                            | ears Months                                                                                                        | Days 9                                 | If LESS than 1 day,hrs. ormin,       | to have occurred on the date stated above, et                                                                                                                                        |
| North work was SAW M                                                                                                                                                                                                                                | r business in which ras done, as SILK MILL, IILL, BANK, etc esed last worked at cupation (month end  city or town) | spe<br>occi                            | ime (years)<br>nt in this<br>upation | Other Contributory Causes of importance:  Curlingue Spline Rudy                                                                                                                      |
| (State or country)  Maryland.  13. NAME Joseph Puckett  14. BIRTHPLACE (city or town) Annapolis. (State or country) Maryland.                                                                                                                       |                                                                                                                    |                                        |                                      | Name of operation Colologue Date of Inay /8 What test confirmed diagnosis? Was there an eutopsy? In                                                                                  |
| 15. MAIDEN NAME Mary J. Williams,  16. BIRTHPLACE (city or town) Annapolis, (State or country) Maryland.  17. INFORMANT Mrs. Theresa M. Puckett (Address) Annapolis, Md.  18. BURIAL, CREMATION, OR REMOVAL Place Annapolis, Md. Date June 5, 19 35 |                                                                                                                    |                                        | and.                                 | 23. If death was due to external causes (VIOLENCE) fill in also the following:  Accident, suicide, or homicide?                                                                      |
| 19. UNDERTAKER                                                                                                                                                                                                                                      | John M. Tay l                                                                                                      | or,                                    | Registrat.                           | Nature of injury  24. Was disease or Injury in any way related to occupation of deceased?  If so, specify  (Signed)  (Address)  M. D                                                 |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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9.—The industry or business in which the work was done.

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| H             | Example II                               |                                                                                                                                                                                                                           |
|---------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of onset | of importance were as follows:           | Date of onset                                                                                                                                                                                                             |
| 1915          | Attack of epilepsy                       | 1 week ago                                                                                                                                                                                                                |
| 1921          | Run over by street car                   | 1 week ago                                                                                                                                                                                                                |
| July 5,1927   | Peritonitis                              | 3 days ago                                                                                                                                                                                                                |
|               | [G3V1303R]                               |                                                                                                                                                                                                                           |
|               | Other contributory causes of importance: |                                                                                                                                                                                                                           |
| May 1,1923    | Gastroenteritis                          | 1 year                                                                                                                                                                                                                    |
| 97 . 15       | in the fire                              |                                                                                                                                                                                                                           |
|               | 1915<br>1921<br>July5,1927               | Date of onset  The principal cause of death and related causes of importance were as follows:  1915  Attack of epilepsy  1921  Run over by street car  July 5,1927  Peritonitis  Other contributory causes of importance: |

| • |  |  |  |
|---|--|--|--|
|   |  |  |  |

V. S. No. 1

06296

| 1. PLACE OF DEATH                                                                                                                                                                                                                       | (34)                                                                                                                                   |         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------|
| County Anne Arundel Village or City Jessup, Maryland                                                                                                                                                                                    | Registration Dist. No. 22 2                                                                                                            | Ward    |
| (If                                                                                                                                                                                                                                     | death occurred in a hospital or institution, give its NAME instead of street and number)  13 ds. How long in U.S. If of foraign birth? |         |
| 2. FULL NAME ROL RAWLINGS  (a) Residence: No.   22 Ox Icans (Usual place of abode)                                                                                                                                                      | St St., Ward. Baltimore Md.  If nonresident give city or town and State                                                                |         |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                    | MEDICAL CERTIFICATE OF DEATH                                                                                                           |         |
| 3. SEX 4. COLOR OR RACE Male Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  5a. If married, widowed, or divorced                                                                                            | 21. DATE OF DEATH  June-25-1935  (Month)  (Day)  (Year)                                                                                | ear)    |
| HUSBANO of Sadel Rawlings                                                                                                                                                                                                               | 22. I HEREBY CERTIFY, That I attended dacease June-12-1935 19 10 June-25-1935 19                                                       |         |
| 6. DATE OF BIRTH (month, day, and yeer) 1076 29 1890                                                                                                                                                                                    |                                                                                                                                        | is seld |
| 7. AGE Years Months Days If LESS than                                                                                                                                                                                                   | to heve occurrad on the data steted ebova, et 5:23. A. M.                                                                              |         |
| 265 44 65 26 1 dey,hrs.                                                                                                                                                                                                                 | The PRINCIPAL CAUSE OF DEATH end related causes of importance were as follows:                                                         |         |
| 8 Turde profession or particular                                                                                                                                                                                                        | Meningo Vascular Lues ?                                                                                                                | ofonset |
| kind of work done, as SPINNER, Jabour                                                                                                                                                                                                   | Pulmonary Edema 6-                                                                                                                     | 24-3    |
| Kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.  9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc.  10. Dete deceesed last worked at this occupation (month and year) spent in this occupetion |                                                                                                                                        |         |
| 12. BIRTHPLACE (city or town) (State or country)  13. NAME  Paudemia                                                                                                                                                                    | Other Contributory Causes of importance:                                                                                               |         |
| 14. BIRTHPLACE (city or town) Bello                                                                                                                                                                                                     | Nema of oparationNoneDate of                                                                                                           | No      |
| 15. MAIOEN NAME  16. BIRTHPLACE (city or town)  (Stete or country)  17. INFORMANT  (Address)                                                                                                                                            | 23. If death was due to external causes (VIOLENCE) fill in also tha following:  Accident, suicide, or homicide?                        |         |
| 18. BURIAL, CREMATION OR SEMOVAL Place 2017 Oate 429 1936                                                                                                                                                                               | Menner of injury  Nature of Injury                                                                                                     |         |
| 19. UNDERTAKER AUTHER SANDLES (Address) 14/3. E. Freestory Sandles                                                                                                                                                                      | 24. Was disaasa or Injury in any way related to occupation of dacaasad?                                                                |         |
| 20. FILED UNE 213, 1985 Blace W. A Oasleh                                                                                                                                                                                               | (Signed) Jessin, Marviand.                                                                                                             | M. D.   |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic scrvice for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arterioselerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street ear                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonilis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

V. S. No. 1

| ż | N. B.—WRITE PLA. LY, WITH UNFADING INK—THIS IS A PERMANENT RE. RD.               | WITH    | UNFADI     | NG II  | VK-T   | HIS | IS A PE     | RMANENT     | RE    | RD.  |
|---|----------------------------------------------------------------------------------|---------|------------|--------|--------|-----|-------------|-------------|-------|------|
|   | mation should be carefully supplied. AGE should be stated EXACTLY. PHYSI         | fully s | upplied.   | AGE    | should | be  | stated F    | XACTL       | Y. PH | YSI  |
| 1 | CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact stat | n plain | terms, so  | that   | it may | be  | properly    | classified. | Exact | stat |
| T | TION is very important. See instructions on back of certificate.                 | nt. Se  | e instruct | ions o | n back | of  | certificate |             |       |      |

| STATE OF MARYLAND-                                                                 | -CERTIFICATE OF DEATH 06297                                                    |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. PLACE OF DEATH                                                                  | (83)                                                                           |
| County Com Countil                                                                 | Registration Dist. No                                                          |
| Village or City Mago Prola,                                                        | NoNoSt                                                                         |
|                                                                                    | osds. How long in U.S. If of foreign birth?yrsmosds                            |
| 2. FULL NAME Sorothy Florence Dricks                                               | the a                                                                          |
| (a) Residence: No. 2921/Wsofwood Dra. (Usual place of abode)                       | St., Ward. Halling And If nonresident give city or town and State              |
| PERSONAL AND STATISTICAL PARTICULARS                                               | MEDICAL CERTIFICATE OF DEATH                                                   |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DLYORCED ("unite the word) | 21. DATE OF DEATH                                                              |
| Osmals While Single                                                                | (Month) (Day) (Yeer)                                                           |
| 5a. If married, widowed, or divorced<br>HUSBAND of                                 |                                                                                |
| (or) WIFE of                                                                       | 22. I HEREBY CERTIFY, That I ettended deceased from                            |
| 6. DATE OF BIRTH (month, day, and year) July 7 1921                                | I lest saw h alive on, 19, 19, 19                                              |
| 7. AGE Years Months Days If LESS than                                              | to have occurred on the date steted ebove, atm.                                |
| 12 11 C I day,hrs.                                                                 | The PRINCIPAL CAUSE OF DEATH and related causes of importence                  |
| 8 Trade profession or particular                                                   | were as follows:                                                               |
| kind of work done, as SPINNER SAWYER, BOOKKEEPER, etc.                             | accordental Novemen.                                                           |
| 9. Industry or business In which work was done, as SILK MILL, SAW MILL, BANK, etc. | no lost involved. a pour suromer:                                              |
|                                                                                    | she stephed but beyond her depth.                                              |
| 10. Date deceased last worked at this occupation (month and year)                  | ews of                                                                         |
| A -                                                                                | Other Contributory Causes of importance:                                       |
| 12. BIRTHPLACE (city or town) Vallimors (State or country)                         | Prouble I teast attach                                                         |
|                                                                                    | - movie o raw allach                                                           |
| 5 20 0                                                                             |                                                                                |
| (State or country)                                                                 | Name of operation Dete of                                                      |
|                                                                                    | Whet test confirmed diagnosis? Was there en eu'opsy?                           |
| 13. WAIDER HAME THE FRUIT FRUITS                                                   | 23. If death was due to external causes (VIOLENCE) fill In also the following: |
| 15. MAIDEN NAME Inlia Januson  16. BIRTHPLACE (city or town) (State or country)    | Accident, suicide, or homicide? 15. Date of injury                             |
| Q 10 11-6.                                                                         | Where did Injury occur? (Specify city or town, county and State)               |
| (Address) 7/9 Edging St. Balls 20                                                  | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.      |
| 18. BURIAL, CREMATION, OR REMOVAL                                                  | Manner of injury Accountal fromma                                              |
| Place I rudow fark Date Here 18, 1935                                              | Nature of injury                                                               |
| lon of file                                                                        | 24. Was disease or injury in any way related to occupation of deceased?        |
| 19. UNDERTAKER M. J. Ordanic Jouline (Address)                                     | If so, specify                                                                 |
| hand 16 22 la direll Man 11 4 M                                                    | (Signed) I Blandsoope J                                                        |
| 20. FILED JUNE 1. 6., 1931 Registrary                                              | (Address) ading Corous                                                         |
| If more blanks are needed, address State Registrar                                 | 2411 N Charles Street Baltimore Properture 71 S.No.                            |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done. 9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                             |
|---------------|--------------------------------------------------------------------------------|-----------------------------------------------------------|
|               |                                                                                |                                                           |
| 1915          | Attack of epilepsy                                                             | 1 week ago                                                |
| 1921          | Run over by street car                                                         | 1 week ago                                                |
| uly 5,1927    | Peritonitis                                                                    | 3 days ago                                                |
| May 1,1923    | Other contributory causes of importance:  Gastroenteritis                      | 1 year                                                    |
|               | Auly 5,1927                                                                    | Other contributory causes of importance:  Gastroenteritis |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| County arme arundal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Registration Dist. No. 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Village or City Dorsey (II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | No. ————————————————————————————————————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Length of residence in city or town where death occurredmos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ds. How long in U.S. if of foreign birth?yrsmosds                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 2. FULL NAME Martha Portio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Ritter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| (a) Residence: No. (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | St., Ward.  If nonresident give city or town and State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 3. SEX 4. COLOR OR RACE France  4. COLOR OR RACE OR DIVORCED (wind the word) OR DIVORCED (wind the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 21. DATE OF DEATH  (Month)  (Day)  (Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 158. If married, widowed, or divorced HUSBAND of (or) WIFE of William a. Ritter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 22. I HEREBY CERTIFY That I attended deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 6. DATE OF BIRTH (month, day, and year) Jan 28 1833                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Mast saw her alive on Jewell 1935; deeth is said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 7. AGE Years Months Days If LESS then 1 day,hrs. ormin.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | to have occurred on the dete stated above, atm.  The PRINCIPAL CAUSE OF DEATH end related causes of importance were as follows:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Note that the second se | Broncho premora 6/13,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Rt Hamiplogia (nd) 6/21/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 10. Date deceased last worked at this occupation (month and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Orimory Chuse: Carehal honorrhage Duration : the days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 12. BIRTIIPLACE (city or town) Cliffy Bolto Co.  (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Other Contributory Causes of importance:  Anyona dial Jacaff (6/1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| II 13. NAME Jeonge Arcallong                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Sementes Scherol arterion acloras as custo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 14. BIRTHPLACE (city or town) 11 Coly, Mid-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Name of operation.  Dete of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 15. MAIDEN NAME MANY SOLON TO THE T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What test confirmed diagnosis? Was there an autopsy? 23. If death was due to external causes (VIOL ENCE) fill in also the following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 16. BIRTHPLACE (city or town). Branches (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Accident, suicide, or homicide? Date of injury, 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 17. INFORMANT Mrs Pearl King                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Where did injury occur?  (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| (Address) Donay Maria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Place Low Dorsey My Date June 28, 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Manner of injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 19. UNDENTAKER W. M. Blook                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 24. Was disease or injury in any wey releted to occupation of deceased?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| (Address) 12/7 Soo garl 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | If so, specify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 20. FILED The n 7, 1935. Caldwell Wood my A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Signed) M. C. M. |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. &

V. S. No. 1

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| Example I                                                                      | - 1           | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    |                                                                                | 1 year        |
| Garriero                                                                       | M ay 1,1925   | Gastroenterius                                                                 | 1 ye          |

| ADDITIONAL     | SPACE    | FOR   | FURTHER         | STATEMENTS | RY   | PHYSICIAN        |
|----------------|----------|-------|-----------------|------------|------|------------------|
| TAN DATEOUTIAL | OR ALCIA | T OTE | T. O TO TITLING | OTATEMENTO | 1) 1 | E EL LOSS / LAIN |

2

| STATE OF MARYLAND—                                                                                                     | CERTIFICATE OF DEATH 06299                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| County a a                                                                                                             | Registration Dist. No.                                                                                                                       |
| Village or City annapolis on                                                                                           | No/6 Hallaup St., Ward                                                                                                                       |
| (If                                                                                                                    | death occurred in a hospital or institution, give its NAME instead of street and number)  ds. How long in U.S. if of foreign birth?yrsmosds. |
| 2. FULL NAME Still Born. Soulos                                                                                        | HUS Voteran openity WAR.                                                                                                                     |
| (a) Residence: No./6 Holland Usual place of abode)                                                                     | St., Ward. If nonresident give city or town and State                                                                                        |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                   | MEDICAL CERTIFICATE OF DEATH                                                                                                                 |
| 3. SEX  4. COYOR OR RACE OR DIVORCED (write the word)                                                                  | 21. DATE OF DEATH 6 2 6 193 3 6                                                                                                              |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of                                                           | 22. I HEREBY CERTIFY, That i attended deceased from                                                                                          |
| 6. DATE OF BIRTH (month, day, and year) 26-1935                                                                        | I last saw h alive on, 19; death is said                                                                                                     |
| 7. AGE Years Montos Days If LESS than                                                                                  | to have occurred on the date stated above, atm.                                                                                              |
| 1 day,hrs.                                                                                                             | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                                               |
| 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEPER, etc.                             | A DA DA TOTA                                                                                                                                 |
| kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.  9. Industry or business in which work was done, as SILK MILL, |                                                                                                                                              |
| SAW MILL, BANK, etc.                                                                                                   | protection mariel                                                                                                                            |
| O 10. Data deceased last worked at this occupation (month and year) year)                                              |                                                                                                                                              |
| 12. BIRTHPLACE (city or town) and folio mo                                                                             | Other Contributory Causes of importanca:                                                                                                     |
| (State or country)                                                                                                     |                                                                                                                                              |
| 13. NAME Wassal Sanda                                                                                                  |                                                                                                                                              |
| 14. BIRTHPLACE (city or town)                                                                                          | Name of operation Date of                                                                                                                    |
|                                                                                                                        | What tast confirmed diagnosis? Was there an autopsy?  23. if death was due to external causes (VIOL ENCE) fill in also the following:        |
| 15. MAIDEN NAME Clinia anchambault  16. BIRTHPLACE (city or town)                                                      | Accident, suicide, or homicide? Data of injury, 19                                                                                           |
| (State or country) Warren fr.                                                                                          | Whera did injury occur?                                                                                                                      |
| 17. INFORMANT Nanial Santes (Address) / Halland Stampolo at                                                            | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                           |
| 18. BURIAL, CREMATION, OR REMOVAL ) Piace Sage Bellin Date 22, 19                                                      | Manner of injury                                                                                                                             |
| 19. UNDERTAKER 3 I Hope (Address) and shall have                                                                       | 24. Was diseasa or injury in any way related to occupation of deceased?                                                                      |
| 20, FILED 6 27, 1935 Munifor Registrar.                                                                                | (Signed) M. D. (Address) M. D.                                                                                                               |
| The many blanks are maded address State Davison                                                                        | Anna N. Charles Street Belgimore Programme 7) S. No. 7                                                                                       |

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I                                                                      |               | Example II                                                                     | - 54          |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |

| ADDITIONAL | SPACE | FOR | <b>FURTHER</b> | STATEMENTS | BY | PHYSICIAN |
|------------|-------|-----|----------------|------------|----|-----------|
|------------|-------|-----|----------------|------------|----|-----------|

BINDIN

MARGIN RESERVED

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

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| erio          | Example II                                                                     | .4                                                                                                                                                                                                                 |
|---------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                                                                                                                                                                                      |
| 1915          | Attack of epilepsy                                                             | 1 week ago                                                                                                                                                                                                         |
| 1921          | Run over by street car                                                         | 1 week ago                                                                                                                                                                                                         |
| July 5,1927   | Peritonitis                                                                    | 3 days ago                                                                                                                                                                                                         |
|               |                                                                                |                                                                                                                                                                                                                    |
|               | Other contributory causes of importance:                                       |                                                                                                                                                                                                                    |
| May 1,1923    | Gastroenteritis                                                                | 1 year                                                                                                                                                                                                             |
|               |                                                                                |                                                                                                                                                                                                                    |
|               | 1915<br>1921<br>July 5,1927                                                    | Date of onset  The principal cause of death and related causes of importance were as follows:  Attack of epilepsy  1921 Run over by street car  July 5, 1927 Peritonitis  Other contributory causes of importance: |

|   | ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN |  |     |  |  |  |
|---|------------------------------------------------------|--|-----|--|--|--|
|   |                                                      |  | ,   |  |  |  |
|   |                                                      |  |     |  |  |  |
| - |                                                      |  | + + |  |  |  |

| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (131)                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| County Grand Counciles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Registration Dist. No.                                                                                                                           |
| Village or City anapolis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | No. Evergency Hospitos? - Ward                                                                                                                   |
| Length of residence in city or town where death occurred byrs. D. mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | If death occurred in a horpital or institution, give its NAME instead of street and number)  sds. How long in U.S. if of foreign birth?yrsmosds. |
| 2. FULL NAME LOVA L Shor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | T WITHIN CORPORATE LIMITE OF                                                                                                                     |
| (a) Residence: No. Serena Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | St Ward.                                                                                                                                         |
| (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | If nonresident give city or town and State                                                                                                       |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                                     |
| 3. SEX 4. COLOR OR RACE OR DIVORCED (write the word)  A while the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 21. DATE OF DEATH  (Month) (Oay) (Year)                                                                                                          |
| 5a. If married, widowed, or divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                  |
| (or) WIFE of Oliver L. Short                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 22. I HEREBY CERTIFY That I attended deceased from                                                                                               |
| 6. DATE OF BIRTH (month, day, and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | I last saw h. A. alive on 2 4 , 19 35; death is seid                                                                                             |
| 7. AGE Years Months Days If LESS than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | to have occurred on the date stated above, at 700 Acm.                                                                                           |
| 5 5 lady, hrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | there as follows or OEATH and letated causes of importance                                                                                       |
| 8. Trade, profession, or particular kind of work done, as SPINNER.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Data of onset                                                                                                                                    |
| SAWYER, BOOKKEEPER, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Grehal bemon bags 6/19/3                                                                                                                         |
| 9 Industry or business in which work was done, as SILK MILL, Quan hame.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Higher lensurs Cardia - Vlafiela-                                                                                                                |
| 10. Dato deceased last worked at this occupation (month and year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Wenne aisense 19301                                                                                                                              |
| 12. BfRTHPLACE (city or town) In mt my Co (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Other Contributory Causes of importance:                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                  |
| 13. NAME  14. BIRTHPLACE (city of town). Many smery so                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Name of operation Date of                                                                                                                        |
| (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What test confirmed diagnosis? Was there an autopsy? No                                                                                          |
| 15. MAIDEN NAME May Gray                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23. If death was due to external causes (VIOLENCE) fill in also the following:                                                                   |
| 16. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Accident, suicide, or homicide? Date of injury, 19                                                                                               |
| (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Where did injury occur? (Specify city or town, county and State)                                                                                 |
| 17. INFORMANT GARAGE THE THE STATE OF THE ST | Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.                                                                        |
| 18. BURIAL, CREMATION, OR BEMOYAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Manner of injury                                                                                                                                 |
| Place W.A. Oliver Oate June \$7, 1930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Nature of Injury.                                                                                                                                |
| 19. UNOERTAKER Wind Collins (Address) 13-17 S.A. Saul S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 24. Was disease or Injury In any way related to occupation of deceased?                                                                          |
| 20. FILEO 6- 25 , 19 35 ) Mariel Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (Signed) Hus Classes M. O. M. O. (Address) 55 Sander Langue                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.                                                                                     |

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|               | Example II                                                                     |                                                                                                                                                                                                         |
|---------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset                                                                                                                                                                                           |
| 1915          | Attack of epilepsy                                                             | 1 week age                                                                                                                                                                                              |
| 1921          | Run over by street car                                                         | 1 week ago                                                                                                                                                                                              |
| July 5,1927   | Peritonitis                                                                    | 3 days ago                                                                                                                                                                                              |
|               | Other contributory causes of importance:                                       |                                                                                                                                                                                                         |
| May 1,1923    | Gastrocnteritis                                                                | 1 year                                                                                                                                                                                                  |
|               |                                                                                |                                                                                                                                                                                                         |
|               | 1915<br>1921<br>July 5,1927                                                    | The principal cause of death and related causes of importance were as follows:  1915 Attack of epilepsy  1921 Run over by street car  July 5,1927 Peritonitis  Other contributory causes of importance: |

|                    | ADDITIONAL SPACE FOR F | URTHER STATEMENTS BY PHYS | ICIAN |
|--------------------|------------------------|---------------------------|-------|
|                    |                        |                           |       |
|                    |                        |                           |       |
| of his son its but |                        |                           |       |
|                    |                        |                           |       |

Trada, profassion, or particular kind of work dona, as SPINNER,

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, atc., 10. Date dacaased last worked at

12. BIRTHPLACE (city or town (State or country)

15. MAIDEN NAME

(Address)

14. BIRTHPLACE (city or town) (State or country)

16. BIRTHPLACE (city or town

18. BURIAL, CREMATION, OR REMOVA

(State or country)

13. NAME

17. INFORMANT

19. UNDERTAKER

FATHER

MOTHER

SAWYER, BOOKKEEPER, etc.

Registration Dist. No. If nonresident give city or town and State MEDICAL CERTIFICATE OF DEATH HEREBY CERTIFY. That I attended daceased from

to have occurred on the date stated above, at 20 A m The PRINCIPAL CAUSE OF DEATH and related causes of importance Date of enset Other Contributory Causes of importance

What test confirmed diagnosis?\_\_\_\_\_ Was there an autopsy?. 23. If death was dua to external causes (VIDLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury\_\_\_\_\_\_ 19. Whera did injury occur?... (Specify city or town, county and State)

Specify whather injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Nature of injury 24. Was disaase or injury

If so, specify (Signed)

If more blanks are needed, address Sodie Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

or ..... min.

11. Total time (years) spent in this occupation

CAUSE LION

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| Example I                                                                      |               | Example II                                                                     |               |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| BUREAU V. S.                                                                   |               |                                                                                |               |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |
|                                                                                |               |                                                                                |               |
|                                                                                |               |                                                                                |               |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1. PLACE OF

County\_\_\_\_\_ Village or City

| STATE OF MARYLAND—                                                         | CERTIFICATE OF DEATH                                                                                                                        |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ДЕАЎН</b>                                                               | (95-E)                                                                                                                                      |
| A. ST:                                                                     | Registration Dist. No.                                                                                                                      |
| Shidmore                                                                   | NoSt.,Ward                                                                                                                                  |
|                                                                            | death occurred in a hospital or institution, give its NAME instead of street and number) ds. How long In U.S. if of foreign birth?yrsmosds. |
| nce in city or lown where death occurredyrsmos                             |                                                                                                                                             |
| E Much Smith                                                               |                                                                                                                                             |
| (Usual place of abode)                                                     | St., Ward.  If nonresident give city or town and State                                                                                      |
| L AND STATISTICAL PARTICULARS                                              | MEDICAL CERTIFICATE OF DEATH                                                                                                                |
| 4. COLOR OR RACE S. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) | 21. DATE OF DEATH (Month) (Day) (Yeer)                                                                                                      |
| naggil South                                                               | 22.   HEREBY CERTIFY, That I attended deceased from 19, 19, 19                                                                              |
| onth, day, end year) KOC, 3, 1846                                          | I last saw h alive on the said                                                                                                              |
| Months Days If LESS than 1 day,hrs.                                        | to have occurred on the date stated above, at the PRINCIPAL CAUSE OF DEATH and related causes of importance                                 |
| on, or particular rk done, as SPINNER, A. J. Colored                       | Avterierjo (15/5 Date of onset                                                                                                              |
| isiness in which<br>jone, es SILK MILL,<br>BANK etc.                       |                                                                                                                                             |

Length of reside 2. FULL NAM (a) Residence PERSONA 3. SEX 5a. If married, widower HUSBAND of (or) WIFE of 6. DATE OF BIRTH (II 7. AGE 8. Trade, profess kind of wo SAWYER. I OCCUPAT Industry or bu work wes 11. Total time (years) spent in this 10. Date deceased last worked at this occupation (month and occupation \_\_\_\_\_ 12. BIRTHPLACE (city or town) (State or country) FATHER 13. NAME Name of operation..... 14. BIRTHPLACE (city or town) (Stete or country) What test confirmed diagnosis? Was there en autopsy? ..... MOTHER 15. MAIDEN NAME 23. If death wes due to external causes (VIOLENCE) fill in elso the following: 16. BIRTHPLACE (city or town) (State or country) Where did injury occur?\_\_\_\_\_ (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. 17. INFORMANT (Address) 18. BURIAL, CREMATION, OR REMOVAL Manner of injury Neture of injury\_\_ 24. Was disease or injury in any way related to occupation of deceased?\_\_ 19. UNDERTAKER (Address) If so, specify. 20. FILED... (Address) Questal Registrar. If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

S. No.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

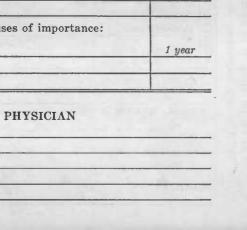
In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

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Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

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| Example I                                                                      |               | Example II                                                                     |            |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|------------|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: |            |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago |
| BUREAU V. St                                                                   |               |                                                                                |            |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |            |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year     |
|                                                                                |               |                                                                                |            |
|                                                                                |               |                                                                                |            |



| гн 66                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 304               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| st. No. 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   |
| nstead of street and m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ward (ward) (sds. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| of DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | State             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |
| レン<br>(Oay)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | , 193(Year)       |
| (Oay)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   |
| That I attended of the state of |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Date of onset     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2./10             |
| Date of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                   |

Accident, suicide, or homicide?\_\_\_\_\_\_ Date of injury\_\_\_\_\_\_, 19

(Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or In PUBLIC PLACE.

(Signed)

20. FILED

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

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|                                                   | Example I                       | j             | Example II                                                                     |               |
|---------------------------------------------------|---------------------------------|---------------|--------------------------------------------------------------------------------|---------------|
| The principal cause of dof importance were as for | eath and related causes ollows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| Arteriosclerosis                                  |                                 | 1915          | Attack of epilepsy                                                             | 1 week ago    |
| Chronic interstitial nephriti                     | s                               | 1921          | Run over by street car                                                         | 1 week ago    |
| Cerebral hemorrhage                               | BUREAU V. S.                    | July 5,1927   | Peritonitis                                                                    | 3 days ago    |
| Other contributory cause                          | es of importance:               |               | Other contributory causes of importance:                                       |               |
| Gallstones                                        |                                 | May 1,1923    | Gastroenteritis                                                                | 1 year        |
| The street plant                                  |                                 |               |                                                                                |               |
|                                                   |                                 |               |                                                                                |               |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

County and town in which death occurred corrected by verbal statement of Clarence W.S.Rutherford, father of deceased, in this Bureau July 12, 1935.-L

| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (131)                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| County To                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Registration Dist. No.                                                                                                               |
| Village or City Daw doon 2, le                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | No. St., Ward                                                                                                                        |
| Length of residence in city or town where death occurred Allyrs Cmos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | death occurred in a horpital or institution, give its NAME instead of street and number)  Als. How long in U.S. if of foreign birth? |
| 2. FULL NAME Du Mack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Thomas                                                                                                                               |
| (a) Residence: No. Au 1-d Ocn 2 100 (Usual place of abode)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | St,WardIf nonresident give city or town and State                                                                                    |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                                         |
| 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (rurrice the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 21. DATE OF DEATH  (Month)  (Day)  (Year)                                                                                            |
| 5a. H married, widowed or divorced HUSDAND OF MM  Across  (or) WIFE of MM  Across  Acr | 22. I HEREBY CERTIFY, That I attended deceased from                                                                                  |
| 6. DATE OF BIRTH (month, day, and year) 1867                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | I last say h la aliye on Accel 6 19 3 1 death is said                                                                                |
| 7. AGE Years Months Days If LESS than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | to have occurred on the date stated above, at 65 Pm.                                                                                 |
| 68 - 1 day,hrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:                                                       |
| 8. Trade, profession, or particular kind of work done, as SPINNER,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Date of onset                                                                                                                        |
| SAWYER, BOOKKEEPER, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Juliano a (Ama O32)                                                                                                                  |
| and Industry or business in which work was done, as SILK MILL, which SAW MILL, BANK, etc  11 Total time (years)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7235                                                                                                                                 |
| this occupation (month end / 93 2 spent in this 9 w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |
| year) occupation occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Other Contributory Causes of importance:                                                                                             |
| 12. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Change & end to the                                                                                                                  |
| 13. NAME By, Cliphy Mack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 100 h. li                                                                                                                            |
| 14. BIRTHPLACE (city or town) have                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Name of operation Date of                                                                                                            |
| (State of County)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What test confirmed diagnosis? Was there an autopsy?                                                                                 |
| 16. BIRTHPLACE (city or town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23. If death was due to external causes (VIOLENCE) fill in also the following:                                                       |
| O 16. BIRTHPLACE (city or town)  (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Accident, suicide, or homicide? Date of injury, 19                                                                                   |
| 17. INFORMANT Slope Mack Mack My (Address) & Marie Denville My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Where did injury occur?                                                                                                              |
| 18. BURIAL, CREMATION, OF REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Manner of injury                                                                                                                     |
| Place Mar Denr. M. Dato flue /2 , 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Nature of Injury                                                                                                                     |
| 19. UNDERTAKER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24. Was disease or Injury In any way related to occupation of deceased?                                                              |
| (Address) Hawdon ill My                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | If so, specify                                                                                                                       |
| 20. FILED June 1/4, 1935 Carrie Suit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Signed) Management of the State of M. D.  (Add/ess)                                                                                 |
| If more blanks are needed, address State Registrar,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2411 N. Charles Street, Baltimore, Requesting U. S. No. 20 ave OSourill                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | man lan                                                                                                                              |

N. B.

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Example I

Example II

| The principal cause of death and related causes of importance were as follows:  Arterioselerosis | Date of onset | The principal cause of death and related causes of importance were as follows:  Attack of epilepsy | Date of onset |
|--------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------|---------------|
| Chronic interstitial nephritis                                                                   | 1921          | Run over by street car                                                                             | 1 week ago    |
| Cerebral hemorrhage                                                                              | July 5,1927   | Peritonitis                                                                                        | 3 days ago    |
| Other contributory causes of importance:                                                         |               | Other contributory causes of importance:                                                           |               |
| Gallstones                                                                                       | May 1,1923    | Gastroenteritis                                                                                    | 1 year        |
|                                                                                                  | 6             |                                                                                                    |               |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

| STATE OF MARYLAND—                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CERTIFICATE OF DEATH 06306                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| I. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (A)3-d) 4                                                                                                          |
| County Classe Urusalel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Rogistration Dist. No. 2                                                                                           |
| Village or City Wear amapole                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | No. Foulle of last St., Ward                                                                                       |
| Length of residence in city or town where death occurredyrsmos.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | death occurred in a hospital or institution, give its NAME instead of street and number)                           |
| Senger of residence in city of town where death occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 S July 10 mg m 0.3. n of foreign birth; 1955.                                                                    |
| 2. FULL NAME Wallace Ground                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Cunko                                                                                                              |
| (a) Residence: No. 1414. O error St. (Usual place of abod Variety                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | St. Ward.  If nonresident give city or town and State                                                              |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL CERTIFICATE OF DEATH                                                                                       |
| 3. SEX 4. COLOR OR RACE OR DIVORCED (write the word) Wale Whate Character Or Divorced (write the word)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 21. DATE OF DEATH  (Month)  (Day)  (Year)                                                                          |
| 5a. If married, widowed, or diverged HUSBAND of (or) WIFE of Luby Lenko,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 22. I HEREBY CERTIFY, That I attended deceased from                                                                |
| 6. DATE OF BIRTH (month, day, and year) Get - 134 /910                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | I last saw h alive on                                                                                              |
| 7. AGE Years Months Days If LESS than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | to have occurred on the date stated above, atm.                                                                    |
| 25 8 9 1 day,hrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | The PRINCIPAL CAUSE OF DEATH and related causes of Importance                                                      |
| 8 Trade, profession, or particular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | were as follows:                                                                                                   |
| kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc Grashloyee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | accedental Drowning                                                                                                |
| 9. Industry or business In which work was done, as SILK MILL and the start of the s | a row-front was insolved cycles                                                                                    |
| kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc.  9. Industry or business In which work was done, as SILK MILL Janusburg Deft. Store  10. Date deceased last worked et this occupation (month and year)  year)  12. Total time (years) spent in this occupation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | made so outroy, went down and drowned.                                                                             |
| 12. BIRTHPLACE (city or town) Mary land (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Other Contributory Causes of importance:                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                    |
| 13. NAME Stephen Sunko                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |
| 14. BIRTHPLACE (city or town) Hew Mrk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Name of operation Date of                                                                                          |
| (State of Country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What test confirmed diagnosis? Was there an au'opsy?                                                               |
| 15. MAIDEN NAME Sarah Cetterson  16. BIRTHPLACE (city or town) - Unguina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 23. If death was due to external causes (VIDLENCE) fill in also the following:                                     |
| 5 16. BIRTHPLACE (city or town) Unguice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Accident, suicide, or homicide secrales Date of Injury 5 19 3., 19 3.                                              |
| ∑ (State or country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Where did injury occur? South Cuer ac Co 2014,                                                                     |
| 17. INFORMANT Long Visual of Washila C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. |
| 18. BURIAL, CREMATION, DR REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Menner of injury                                                                                                   |
| Place Hyattserlle Mel. Date June 23, 1935                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Nature of injury                                                                                                   |
| 04                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24. Was disease or injury in any way related to occupation of deceased?                                            |
| 19. UNDERTAKER MANCES VASCHA HONO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | If so, specify                                                                                                     |
| 180 310 AMIL 1-1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (Signed) to the Mellinstrong                                                                                       |
| 20, FILED O Registrar.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Address annapolis Md.                                                                                             |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, ctc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injurics. Examples:

Example I Example II The principal cause of death and related causes The principal cause of death and related causes Date of onset Date of onset of importance were as follows: of importance were as follows: Arteriosclerosis 1915 Attack of epilepsy 1 week ago Chronic interstitial nephritis 1921 Run over by street car 1 week ago Cerebral hemorrhage Julu5.1927 Peritonitis 3 days ago Other contributory causes of importance: Other contributory causes of importance: Gallstones May 1,1923 Gastroenteritis 1 year

| ADDITIONAL | SPACE FO | R FURTHER | STATEMENTS | BY | PHYSICIAN |
|------------|----------|-----------|------------|----|-----------|
|------------|----------|-----------|------------|----|-----------|

if more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Refuesting

(If death occurred in hospital or institu-

(Day)

(Approved by U.S. Census and American Public Health Association.)

state occupation at beginning of illness. If retired from gaged in domestic service for wages, as Servant, Cook, en at home, who are engaged in the er," etc., worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deal-Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; should be used only when needed. As examples: (a) a !ditional line is provided for the latter statement; it nature of the business or industry, and therefore an sary to know (a) the kind of work and also (b) the cases, especially in industrial employments, it is neces-Physician, Compositor, Architect, Locomolive engineer, the first line will be sufficient, e. g., Farmer or Planter, cupation is very important, so that the relative healthbut iness, that fact may be indicated thus: Furmer (reor given up on account of the disease causing DEATH. ployed, as At school or At home. Care should be taken work, or At Home, and children, not gainfully emdefinite salary), may be entered as Housewife, House. household only (not paid Housekeepers who receive a laborer, Farm laborer, Laborer-Civil engineer, Stationary firemen, etc. But in many tion applies to each and every person, irrespective of fulness of various pursuits can be known. The ques-Housemeid, etc. If the occupation has been changed to report specifically the occupations of persons en-(a) Foreman, (b) Automobile factory. The material Latever, write None. (red 6 yrs.). For persons who have no occupation Statement of Occupation-Precise statement of oc For many occupations a single word or term on without more precise specification as -Coal mine, etc. Womduties of the

Statement of Cause of Death—Name, first, the Disease Causing Death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia."): Lobar pneumonia, Bronchopneumonia ("Pneumonia,")

head of "contributory." quences (e.g., sepsie, tetanus) may be stated under the diseases resulting from childbirth or miscarriage as ean be ascertained as the cause. rhage," "Inaultion." "Marasmus," "Old Age," "Shock," "Dropsy," "Exhaustion," "Heart failure," "Haemorsymptomatic), "Atrophy," "Collapse," "Coma," conditions, such as "Asthenia," "Anaemia" (merely ary), 10 ds. Never report mere symptoms or terminal causing death), 29 ds.; Bronchopneumonia (second stated unless important. Chronic interstitial nephritis, etc. use of "Tumor" for malignant neoplasms); unqualified, is indefinite); Tuberculosis of lungs, men-Nomenclature of the American Medical Association.) ment of cause of death approved by Committee on train-accident; Revolver wound of head-homicide; as probably such, if impossible to determine definitely and qualify as ACCIDENTAL, SUICIDAL, OF HOMICIDAL, OF "Puerperal septicaemia," "Puerperal peritonitis," "Uraemia," "Weakhese." etc., when a definite disease myes, peritonaum, etc., ture of the injury, as fracture of skull, and conse-Poisoned by carbolic acid-probably sulcide. Examples: Accidental drowning; State cause vulsions," (secondary or intercurrent) affection need not be Whooping cough; Chronic valvular heart disease; ..... (name origin; "Cancer" is less definite; avoid FOR VIOLENT DEATHS STATE MEANS OF INJURY "Debility" for which surgical operation was under ("Congenital," "Senile," ctc.), Carcinoma, Sarcoma, etc., of (Recommendations on state-Example: Measles Always qualify all Struck by railway The contributory Measles; (disease etc.

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Il so, specily

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Registrar.

19. UNDERTAKER (Address)

Date of onset

(Day)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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- 8.—The trade, profession, or particular kind of work done.
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In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I                                                                      |               | Example II                                                                     |               |  |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|--|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |  |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |  |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |  |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |  |
|                                                                                |               |                                                                                |               |  |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |  |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |  |
|                                                                                |               |                                                                                |               |  |
|                                                                                |               |                                                                                |               |  |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

V. S. No. 1

| STATE OF | MARYLAND-CERTIFICATE | OF | DEATH |
|----------|----------------------|----|-------|
|          | A.                   |    |       |

| 0 | 0 | 9 | 1 | 0 |
|---|---|---|---|---|
| 0 | U | J | V | J |

|                                                  | OF DEATH Anne Arund                                                          | el                   |                                             | Registration Dist. No.                                                                                                                                          | 7/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------|------------------------------------------------------------------------------|----------------------|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| County                                           | <b>A</b>                                                                     |                      | State Hosp                                  | 4.4                                                                                                                                                             | Ward                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Village or Length of r                           | residanca In city or town wha                                                |                      | 2 (lí<br>1 yrs, mos                         | St., St., St., St., St., St., St., St.,                                                                                                                         | ward with the second se |
|                                                  |                                                                              | ester (              | County, Mar                                 | Ylsind Ward.  If nonresident give city or town and                                                                                                              | State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                  | ONAL AND STATIS                                                              |                      |                                             | MEDICAL CERTIFICATE OF DEATH                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| s. SEX<br>male                                   | 4. COLOR OR RACE<br>ble ok                                                   | S. SINGLE,<br>OR DAY | MARRIED, WIDOWED,<br>DRCED (write the word) | 21. DATE OF DEATH June 4th                                                                                                                                      | , 193                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 5a. If marriad, wid<br>HUSBAND o<br>(or) WIFE of |                                                                              |                      |                                             | 22. March ESERY C58 TIFY Ale 44 Med                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| S DATE OF RIRT                                   | TH (month, day, end yaar)                                                    | 1900                 |                                             | l last saw h alive on June 4th 33                                                                                                                               | ; death is said                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                  | Years Months                                                                 | Day:                 | If LESS than I dey,hrs. ormin.              | to have occurred on the dete stated above, at 6:494m.  The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:  General parelysis of the | Date of onset                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| kind                                             | ofassion, or perticular<br>of work dona, as SPINNER,<br>rER, BOOKKEEPER, etc | Unkn                 | o w <b>n</b>                                | Insane                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 9. Industry<br>work                              | or businass in which<br>was dona, as SILK MILL,<br>MILL, BANK, etc           |                      |                                             |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 10. Date dec                                     | MILL, BANK, etcaasad last worked et ccupation (month end                     | 11. 7                | Total tima (yaers) spant in this occupation |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 12. BIRTHPLACE                                   | (city or town)                                                               | arylan               | đ                                           | Other Contributory Causes of importance:                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                  |                                                                              | nlmown               |                                             |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                  | ACE (city or town)                                                           | ln)cno wn            |                                             | Name of operation Date of What test confirmed diagnosis? Wes there en                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| -                                                | Tran                                                                         | mown                 |                                             | 23. If daeth was due to extarnal causes (VIDLENCE) fill in also the followin                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                  | ACE (city or town)<br>e or country)                                          | Unknow               |                                             | Accidant, suicide, or homicide? Date of injury  Whare did injury occur? (Specify city or town, county and Sta                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 17. INFORMANT .<br>(Addrass)                     | ( 10 () 1 20 (797 )                                                          | Record               | s<br>ryland                                 | Spacify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PL                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 18. BURIAL, CREI                                 | MATION, OR REMOVAL                                                           | U. Date 6            | -7-35,19                                    | Manner of injury                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 19. UNDERTAKE                                    | Contibu                                                                      | Vad                  | my.                                         | 24. Was disease of injury in any way ralated to occupation of dacassad?                                                                                         | S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 20. FILED                                        | 4 ,1935                                                                      | JAN .                | Registrar.                                  | (Signed) (Addrass)                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

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9.—The industry or business in which the work was done.

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| Example I                                                                      | t t           | Example II                                                                     |               |  |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|--|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |  |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |  |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |  |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |  |
| BITREAU V. S.                                                                  |               |                                                                                |               |  |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |  |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |  |
|                                                                                |               |                                                                                |               |  |
|                                                                                |               |                                                                                |               |  |

### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Dirihes Ir Go inty mitted Haroh 12, 1925 hed June 4th, 1925

V. S. No. 1

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|    |                     | STATE OF MARY                          | YLAND—CE        | RIFICA                 | IE OF DEP                             | ATH UO                      | 310   |
|----|---------------------|----------------------------------------|-----------------|------------------------|---------------------------------------|-----------------------------|-------|
| 1. | PLACE OF DE         | EATH                                   |                 | (6)                    | 3.0)                                  |                             |       |
|    | County              | Anne Arundel                           |                 | 6.5                    | Registration                          | Dist. No. 21                |       |
|    | Village or City     | Eastport                               |                 | No. Horn               | Point  I or institution, give its NAM |                             | Ward  |
|    | Length of residence | in city or town where death occurred 2 | 5 use (If death | occurred in a hospital | lor institution, give its NAM         | E instead of street and num | nber) |
| 1  |                     | LAURASTEINA WHE                        |                 | zaads. How rong in     | 0.3.11 01 loreign birth:              |                             |       |
| Z. |                     |                                        |                 |                        |                                       |                             |       |
|    | (a) Residence: No   | Horn Point, Eas                        | tport, Md-s     | St., Ward.             |                                       |                             |       |

| County A                                                                                                                       | me Wr       | mure T                        |                                  |                                                 |                       | Registrat               | ion Dist. No.              |               |
|--------------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------------|----------------------------------|-------------------------------------------------|-----------------------|-------------------------|----------------------------|---------------|
| Village or City                                                                                                                | Eastpo      | rt                            |                                  | No                                              | Horn                  | Point                   | AME instead of street ar   | Ward          |
| Length of residence in city or to                                                                                              |             | 2                             | 5 - (11                          |                                                 |                       |                         |                            |               |
|                                                                                                                                |             |                               |                                  | sas. n                                          | ow long in U          | .5. If of foreign birth | ?yrs                       | _mosds.       |
| 2. FULL NAME LAU                                                                                                               |             |                               |                                  |                                                 |                       |                         |                            |               |
| (a) Residence: No. Hor                                                                                                         | n Poin      | (Usual place                  | tport, M                         | de St.,                                         | Ward.                 | If consessi             | deot give city or town     | and Conta     |
| PERSONAL AND ST                                                                                                                | ATISTICA    |                               |                                  |                                                 | MEDICA                |                         | TE OF DEATH                |               |
| 3. SEX 4. COLOR OR white                                                                                                       | RACE 5.     | SINGLE, MARI                  | RIED, WIDOWED, (write the word)  | 21. DATE                                        |                       | TH June                 | 6                          | , 193.5       |
| 5a. If married, widowed, or divorced                                                                                           | ,           | mar 1 20                      |                                  |                                                 |                       | (Month)                 | (Oay)                      | (Year)        |
| HUSBAND of (or) WIFE of John W                                                                                                 | . Whea      | tley                          |                                  | 22. Ja                                          |                       | EBY CERT                | FY. That I attend          | -             |
| 6. DATE OF BIRTH (month, day, and y                                                                                            | ear) Jun    | e 20.                         | 1893                             | I lask saw h                                    | alive                 | on June                 | 16 ,193                    | death Is seid |
| 7. AGE Years                                                                                                                   | Months      | Days                          | If LESS than                     |                                                 |                       | te stated above, at 1.  |                            |               |
| 41                                                                                                                             | 11          | 17                            | I day,hrs.                       | The PRINCIPA                                    |                       | F DEATH and related     | causes of importance       | Data of onset |
| 8. Trade, profession, or particula kind of work done, as SPI SAWYER, BDDKKEEPER, et                                            | NNER.       | none                          |                                  | 1                                               |                       | noma                    |                            | Data of onset |
| kind of work done, as SPI SAWYER, BDDKKEEPER, et 9. Industry or business in which work was done, as SILK M SAW MILL, BANK, etc | ILL,        |                               |                                  | Cancar                                          | in Person             | norma Class             |                            |               |
| 10. Date deceased last worked at this occupation (month and year)                                                              |             | 11. Total tin<br>spen<br>occu | me (years)<br>tin this<br>pation | Dura                                            | Loni. 3               | ne yaov.                |                            |               |
| 12. BIRTHPLACE (city or town) (State or country)                                                                               | Balti<br>Ma | more,                         |                                  | Other Contribu                                  | Must                  | of importance:          |                            |               |
| I 13. NAME James                                                                                                               | Pearma      | n.                            |                                  |                                                 |                       |                         | 7                          |               |
| 13. NAME James 14. BIRTHPLACE (city or town) (State or country)                                                                | D.          | ltimor<br>Maryl               |                                  | Name of opere                                   | •                     |                         | Xxay Date of Was there a   |               |
| 15. MAIDEN NAME Lau                                                                                                            | ra Joy      |                               |                                  |                                                 | The state of the same | man 1997 Carlotte       | E) fill in also the follow |               |
| 15. MAIDEN NAME Laura Joyce  16. BIRTHPLACE (city or town) A. A. County  (State or country) Md.                                |             |                               |                                  |                                                 | de, or homici         | de?                     | Oate of injury             |               |
| 17. INFORMANT Mrs. Gil<br>(Address) Horn Poi                                                                                   |             |                               | (Specify cit                     | y or town, county and S<br>n HDME, or in PUBLIC | itale)<br>PLACE.      |                         |                            |               |
| 18. BURIAL, CREMATION, OR REMOVA                                                                                               | L           |                               |                                  | Manner of inju                                  |                       |                         |                            |               |
| 19 UNDERTAKER John M.                                                                                                          | Tay lo      | r,                            |                                  |                                                 |                       | any way related to oc   | ccupation of deceased?     | no            |

(Address) If so, specify (Signed) 20. FILED.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. Solio. I.

Statement of occupation .- Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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RECEIVED In stating the occupation, avoid the use of such indefinite terms as "cmployce," "worker," "gggrative," etc. Find the particular kind of work done and return that, as spinner, weaver, etc.

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### ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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| ý . |  |
|     |  |

V. S. No. 1

3

(Address)

|              | STATE OF MARYLAND—                                              | CERTIFICATE OF DEATH 06311                                                                                                          |
|--------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
|              | 1. PLACE OF DEATH                                               | 93-2                                                                                                                                |
| 1            | County (e. a. ley)                                              | Registration Dist. No. 23                                                                                                           |
| 1            | Village or City Burishyn blandauch                              | NoSt.,Ward                                                                                                                          |
| 1            | Length of residence in city or town where death occurred        | death occurred in a horpital or institution, give its NAME instead of street and number)  ds. How long in U.S. If of foreign birth? |
|              | 2. FULL NAME Richard J. William                                 | 1                                                                                                                                   |
|              | (a) Residence; No.                                              | St Ward.                                                                                                                            |
|              | (Usual place of abode)                                          | If nonresident give city or town and State                                                                                          |
|              | PERSONAL AND STATISTICAL PARTICULARS                            | MEDICAL CERTIFICATE OF DEATH                                                                                                        |
|              | 3. SEX 4. COLOR OR RACE OR DIVORCED (write the word)            | 21. DATE OF DEATH  12 193                                                                                                           |
|              | 5a. If married, widowed, or divorced HUSBANO of                 | (Month) (Oay) (Year)                                                                                                                |
|              | (or) WIFE of Sarah Jane // Illiamo                              | 1 HEREBY CERTIFY That I attended deceased from                                                                                      |
| certificate. | 6. DATE OF BIRTH (month, day, and year) Line 94 th 1859         | Last saw h in alive on frame 11, 19 34; death is said                                                                               |
|              | 7. AGE Years Mooths Days If LESS than                           | to heve occurred on the date stated above, at & T. m.                                                                               |
| tif          | 75 11 18 1 day,hrs.                                             | The PRINCIPAL CAUSE OF DEATH and related causes of importence were as follows:                                                      |
|              | Trade profession or particular                                  | Oate of onset                                                                                                                       |
| of           | kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.         | Chronic Myscarditis Semility ?                                                                                                      |
| back         | work was done, es SILK MILL,                                    | arterios lesosis d ?                                                                                                                |
| no           | 11. Total time (years) this occupation (month and spent in this |                                                                                                                                     |
| ons          | year) occupation                                                | Other Contributory Causes of importance:                                                                                            |
| ucti         | 12. BIRTHPLACE (city or town) Mayland (State or country)        | 1 2 2                                                                                                                               |
| instructions | 13. NAME GRAGE W ON: Plicases                                   | Cromuse omchofneumona - loday                                                                                                       |
| See          | 14. BIRTHPLACE (city or town)                                   | Name of operation Oate of                                                                                                           |
|              | (State of country)                                              | What test confirmed diegnosis? Climaso. Was there an autopsy? ho                                                                    |
| ant          | 16. BIRTHPLACE (city or town) Mary and:                         | 23. If death was due to external causes (VIOLENCE) fill in also the following:                                                      |
| ort          | [State or equality)                                             | Accident, suicide, or homicide?                                                                                                     |
| important.   | (1)                                                             | Where did injury occur? (Specify city or town, county and State)                                                                    |
| very         | 17. INFORMANT ( Felley Milleary) (Address) Burkelyn Maryland    | Specify whether injury occurred in INOUSTRY, in HOME, or in PUBLIC PLACE.                                                           |
| is ve        | 18. BURIAL, CREMATION, OR REMOVAL                               | Manner of Injury                                                                                                                    |
|              | Plece Mr. Calvary Country Octo fline / 4 4, 1935                |                                                                                                                                     |
| TION         | 19. UNDERTAKER (rehifald a Garding)                             | 24. Was disease or injury in any way related to occupation of deceased?                                                             |

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

Registrar.

If so, specify

(Address) 1009

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| ADDITIONAL S | SPACE | FOR | FURTHER | STATEMENTS | BY | PHYSICIAN |
|--------------|-------|-----|---------|------------|----|-----------|
|--------------|-------|-----|---------|------------|----|-----------|

egistrar.

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| 17                                                   | ation Dist. No      | W                      |
|------------------------------------------------------|---------------------|------------------------|
| No. Emergency Hot                                    | fulal               | St., Ward              |
| death occurred in a hospital or institution, give in | VAME instead of s   | treet and number)      |
| ds. How long in U.S. if of foreign birt              |                     |                        |
| WITHIN C                                             | BRPORATE LI         |                        |
| ed St. Ward.                                         |                     | MITS                   |
| If nonre                                             | sident give city or |                        |
| MEDICAL CERTIFIC                                     | ATE OF DE           | ATH                    |
| 21. DATE OF DEATH                                    | 7                   | 3 ,-                   |
| (Month)                                              | (Day)               | , 193 O<br>(Year)      |
|                                                      | (50)                | (1681)                 |
| 1/41 - 10 -1-                                        | IFY That I          | attended deceased from |
| 1933,1                                               | , your              | 2, 19. 20              |
| last saw h. Lelive on                                | 25                  | 19_25; deeth is said   |
| to heve occurred on the date stated above, at        | 8 - 12 m.           |                        |
| The PRINCIPAL CAUSE OF DEATH end relete              | d causes of importa |                        |
| Sweety reglit                                        | Tediele             | Date of onset          |
| Janarenales v                                        | ald to              | ele 012                |
| Forage, Lines                                        | a Reuta             | 1435                   |
|                                                      | J. J. L.            |                        |
|                                                      |                     |                        |
| Other Contributory Cause of importence               | 0 0                 |                        |
| Paralytico.                                          | Dlen                | 0                      |
|                                                      |                     |                        |
|                                                      |                     | 7                      |
| Name of operation Leach Salpe                        | randott             | Date of State of       |
| What test confirmed diegnosis? Official              | des Wast            | here an europsy? Als.  |
| 23. If death was due to external ceuses (VIOL EN     | _                   |                        |
| Accident, suicide, or homicide?                      |                     |                        |
| Where dld injury occur?                              | Date of injury      | f, 19                  |
| (Specify of                                          | ity or town, county | and State)             |
| Specify whether injury occurred in INDUSTRY,         | in HOME, or In PU   | BLIC PLACE.            |
| Minain of Latina                                     |                     |                        |
| Menner of injury                                     |                     |                        |
| Neture of injury                                     |                     |                        |
| 24. Was disease or injury in any wey related to      | occupation of dece  | ased?                  |
| If so, specify                                       | -11                 | d                      |
|                                                      |                     |                        |

V. S. No. 1

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Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example 1                                                                      | 11            | Example II                                                                     |               |  |  |
|--------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------|---------------|--|--|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |  |  |
| Arteriosclerosis                                                               | 1915          | Attack of epilepsy                                                             | 1 week ago    |  |  |
| Chronic interstitial nephritis                                                 | 1921          | Run over by street car                                                         | 1 week ago    |  |  |
| Cerebral hemorrhage                                                            | July 5,1927   | Peritonitis                                                                    | 3 days ago    |  |  |
| Other contributory causes of importance:                                       |               | Other contributory causes of importance:                                       |               |  |  |
| Gallstones                                                                     | May 1,1923    | Gastroenteritis                                                                | 1 year        |  |  |
|                                                                                |               |                                                                                |               |  |  |

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If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. V.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.-The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," ctc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, ctc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

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|                                                                              |                   |                                                                                |               |

| ADDITIONAL | SPACE | FOR | <b>FURTHER</b> | STATEMENTS | BY | PHYSICIAN |
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